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AUTHOR Acampora, Alfonso P., Ed.; Nebelkopf, Ethan, Ed.
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ABSTRACT

This document contains 10 papers from the ninth World Conference of Therapeutic Communities (TC) that deal with a variety of health-related subjects. Papers include: (1) "AIDS among IV Drug Users: Epidemiology, Natural History & TC Experiences" (Don C. Des Jarlais, et al.); (2) "AIDS and Therapeutic Communities: Policy Implications" (Don C. Des Jarlais and Samuel R. Friedman); (3) "Can Recovering Addicts Drink?" (David E. Smith); (4) "Alcohol and the TC Graduate: The Permissions Model" (Alfonso P. Acampora); (5) "Firewater: An Archetypal Perspective" (Eduardo Duran); (6) "Designer Drugs: The Analog Game" (Robert J. Roberton); (7) "Treatment of Cocaine Dependence within the TC System" (Joan Zweben); (8) "Herbs & Alternative Health in the TC" (Ethan Nebelkopf); (9) "Nutrition & Dietary Concerns in the TC" (Donald Land); and (10) "Run for Recovery: An Insider's View" (Frank M.) (NB)

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CHAPTER 4

AIDS, ALCOHOL & HEALTH CARE

AIDS AMONG IV DRUG USERS: EPIDEMIOLOGY, NATURAL HISTORY AND THERAPEUTIC COMMUNITY EXPERIENCES

Don C. Des Jarlais, Ph.D., Nancy Jainchill, M.A. & Samuel R. Friedman

Division of Substance Abuse Services &
Phoenix House Research Department
New York, NY

Introduction

Acquired immunodeficiency syndrome (AIDS) is emerging as one of the greatest public health problems of the decade. The first United States cases were reported in the summer of 1981, and the number has risen to 13,216 through Sept. 20, 1985. Intravenous (IV) drug users form the second largest group of perons who have developed AIDS in the U.S. Three thousand three hundred ninety-three (26%) of the cases have occurred in IV drug users, including 1144 IV drug users who also have a history of male homosexual activity (1).

The number of cases of AIDS represents only a small fraction of the persons who have been exposed to Human T Cell Lymphotropic Virus type III/Lymphadenopathy Associated Virus (HTLV-III/LAV), the virus that is the primary cause of AIDS. Estimates of the number of persons who already have been exposed range up to 2 million. At present the number of exposed persons who will develop the full syndrome is unknown, with most estimates around ten percent.

Currently there are no effective treatments for AIDS, and the disease is almost uniformly fatal. Approximately three quarters of diagnosed cases die within two years of initial diagnosis (2). There is also no effective vaccine for the prevention of the syndrome. While there is intensive research in developing a vaccine, the rate of genetic change in the virus makes development of a vaccine much more difficult (3).

In this paper, we will summarize data on the epidemiology of AIDS among IV drug users, on the natural history of HTLV-III/LAV infection, and on the experiences of therapeutic communities with AIDS. A companion paper discusses the policy implications of AIDS for therapeutic communities.

Epidemiology

The development of antibody tests for exposure to HTLV-III/LAV has greatly improved our ability to conduct epidemiologic studies of AIDS among IV drug users for several reasons. Previously, epidemiologic research had to use actual cases of surveillance definition AIDS as a dependent variable. The long and variable time period between viral exposure and development of the disease (4) and the high ratio of exposed persons to AIDS cases at any single point in time both make numbers of exposed persons a much more powerful variable for analysis than numbers of AIDS cases.

It is clear that the sharing of works for injecting drugs is the primary method of transmitting HTLV-III/LAV virus among IV drug users (5,6). In terms of viral transmission, "needle sharing" should be defined to include the sharing of the syringes used for injection, and possibly even the "cookers" used for preparation of the drugs. Heroin and cocaine are by far the most commonly injected drugs among IV drug users who have been exposed to the HTLV-III/LAV virus, but the particular drug being injected does not appear to play an important part in the spread of the virus (7).

In the United States, the AIDS epidemic in IV drug users is centered in the New York City metropolitan area. Our 1984 studies of HTLV-III/LAV seropositivity among IV drug users in New York City showed approximately 60% of the IV drug users had been exposed to the virus. This did not vary significantly among subjects recruited from methadone maintenance, detoxification or therapeutic communities (8). Studies conducted by Weiss and colleagues (9) in New Jersey show a range from 50% seropositive in the northern part of the state, near New York City, to only 2% in the southern part of the state. Studies of seroprevalence in San Francisco and Chicago found approximately 10% postive in both cities (10). Clearly the AIDS epidemic among IV drug users is most advanced in the New York City area, but it has also started in

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other cities with large numbers of IV drug users. Prevention efforts are needed throughout the country, but particularly in areas like San Francisco and Chicago, where the great majority of IV drug users have not yet been exposed to the virus.

We have also conducted historical studies of the epidemic in New York City, using serum samples that were originally collected for other purposes. We have sera from IV drug users that go back to the middle 1960's. The first indication of HTLV-III/LAV antibody presence is in one of eleven samples from 1978. Seroprevalence then increses greatly--29% of 40 samples in 1979 were positive, 44% of samples from 1980, and 52% of samples from 1982 (11). The HTLV-III/LAV virus appears to have been introduced among IV drug users in the late 1970's in New York City and the seroprevalence rate has increased by about 5% per year since then.

Data on HTLV-III/LAV seroprevalence among IV drug users in countries of the world is somewhat limited, but does indicate that the virus is well established among IV drug users in continental Europe. There is are published reports showing 36% seropositivity among IV drug users in Zurich (12) and 34% among IV drug users in Germany (13), and preliminary data showing approximately 20% among IV drug users in Holland (14), 30% among IV drug users in Milan (15), and 20% among IV drug users in Stockholm (16). In contrast to the continent, a report from London showed only 1.5% serpositivity among IV drug users (17). At present, there is no comprehensive explanation for the variation in HTLV-III/LAV seropositivity rates among IV drug users in different parts of the world. Hypotheses are being tested to see if differences in needle sharing between male homosexual and heterosexual IV drug users, or in male homosexual prostitution among IV drug users, may account for the variation. Research is being conducted to test these. Regardless of the exact reasons for these geographical differences, it is clear that the AIDS problem among IV drug users must be considered a truly international one, and not confined to the United States.

In the United States, IV drug users form a link to two other groups at increased risk for AIDS-heterosexual partners and children. Of the 186 cases of AIDS among children reported through Sept. 20, 1985, 98 (53%) had an IV drug using parent. Of the 133 cases reported where heterosexual transmission appears to be the route of exposure, 97 (73%) involved transmission from an IV drug user. In the U.S., heterosexual transmission appears to be almost exclusively from male to female. Only 13 of the heterosexual transmission cases are male (18). Reasons for the great preponderance of females are currently under investigation.

Risk Reduction

There is a common stereotype that IV drug users are not at all concerned about health, and are not likely to change their behavior in order to avoid exposure to HTLV-III/LAV. Much of the stereotype appears to be based on observations of very unsanitary "shooting galleries" (19,20). Despite this stereotype, there is consistent evidence from a variety of sources to show that IV drug users in New York City have changed their behavior in order to reduce the chances of exposure to the AIDS virus.

We have conducted studies using interviews of IV drug users in treatment (21), not in treatment (22), and of persons selling needles for drug injection (23). All of these studies showed that IV drug users in New York City knew of AIDS, and the great majority (approximately 90%) knew that it was spread through sharing needles. Approximately 60% of the subjects reported efforts to reduce the chances of exposure to the AIDS virus, primarily through increased use of sterile needles. This self-reported increase in sterile needles was confirmed in our interviews of persons selling needles, who reported an increase in demand for sterile needles as a direct result of the AIDS epidemic. Limited availability of sterile needles was also noted as a major constraint on risk reduction in our studies of IV drug users not in treatment.

It is not yet possible to quantify precisely the amount of reduced needle sharing that has occurred among IV drug users in New York City. Drawing a truly random sample of IV drug users, and then monitoring their behavior over time, would be an enormously complex research undertaking. All of our present evidence, however, does indicate that efforts to reduce transmission of HTLV-III/LAV are occurring as a result of knowledge of AIDS. IV drug users should not be considered unresponsive to the threat of AIDS. (Some of the specific issues regarding possible ways to increase risk reduction among IV drug users not in treatment are discussed in the accompanying policy issues paper.)

Natural History

The course of HTLV-III/LAV infection after a diagnosis of AIDS has been well studied, but there is comparatively little knowledge of the early "natural history" of HTLV-III/LAV infection among IV drug users. Important aspects of the natural history yet to be determined include significant events in the early

course of the infection, the different possible outcomes for IV drug users exposed to the HTLV-III/LAV virus and the distribution of exposed persons across the different outcomes.

We are currently following a group of over 300 IV drug users, approximately 60% of whom have been exposed to HTLV-III/LAV. This will permit us to monitor the early course of HTLV-III/LAV infection as well as to determine the various possible outcomes. The decline of T4 (helper) cells to an abnormally low level appears to be an important marker in the infection process. This event is associated with a variety of changes in immunologic status, including increases in serum immunoglobulins and serum beta-2 microglobulin, and increases in ARC symptoms (24). It may mark a point where serious impairment of the immune system begins, and after which treatment may need to include reconstitution of the immune system as well as halting HTLV-III/LAV viral replication.

Surveillance definition AIDS and AIDS-related complex (ARC) are the two best known outcomes of HTLV-III/LAV infection, but certainly not the only possible ones. Most IV drug users exposed to HTLV-III/LAV will probably not develop AIDS or any other significant health problems as a result. There is, however, increasing evidence of direct HTLV-III/LAV effects upon the central nervous system, leading to a syndrome that resembles Alzheimer's disease (25). There have also been epidemics of non-AIDS pneumonia and tuberculosis among IV drug users in New York City that coincide with the AIDS epidemic (26), and preliminary indications in our data of increased rates of endocarditis among IV drug users exposed to HTLV-III/LAV. It is important to determine if exposure to HTLV-III/LAV does increase susceptibility to these other serious illnesses that are not normally associated with AIDS. Given the large number of persons who have already been exposed to HTLV-III/LAV, we need knowledge of the full range of possible outcomes from exposure.

One of the most frequently asked questions regarding the natural history of HTLV-III/LAV infection is the likelihood of developing AIDS. The most common estimates center on ten per cent of those exposed developing surveillance definition AIDS. In our present study we have found 2.5% developing AIDS within the first year of follow-up, which is consistent with an overall estimate of ten per cent. In light of the other possible outcomes noted above, many of which are disabling or fatal in themselves, the percentage of persons who develop severe health problems as a result of HTLV-III/LAV exposure will very likely be much greater than ten per cent.

Co-Factors

Our follow-up of HTLV-III/LAV exposed IV drug users is also being used to examine possible co-factors that might influence the progression of HTLV-III/LAV infection. Given the absence of effective treatment and large numbers of persons who have already been exposed to the virus, identification of co-factors may have great potential for reducing the adverse consequences of viral exposure. If co-factors involve modifiable behavior, then it may be possible for many persons who have already been exposed to take actions that would reduce the chances of adverse outcomes.

The potential co-factors that we are examining include continued drug injection/repeated exposure to the virus, exposure through multiple routes, use of non-injected drugs (particularly alcohol and marijuana), stress, and other illnesses. Our preliminary findings indicate that multiple exposure to the virus may have deleterious effects, and recommendations to persons who have already been exposed should advise against activities that may lead to additional exposures.

Therapeutic Communities and AIDS

The most knowledgable individual at each of 15 therapeutic communities in different parts of the United States was interviewed by telephone in order to assess the prevalence, treatment and particular concerns about AIDS in therapeutic communities. Results of the interviews are briefly summarized below.

Five of the TCs reported having residents with AIDS in treatment. In an additional TC, there were clients who tested positive to the HTLV-III/LAV virus, but who were otherwise asymptomatic. All of the TCs with active cases made the existence of the cases known to residents, but only one community disclosed the client's identity. Five of the 15 TCs reported that residents had been diagnosed as having AIDS after leaving treatment.

Programs were also asked if clients who had already been diagnosed with AIDS or AIDS related illness had been accepted into treatment. Four programs had accepted individuals who were symptomatic, 1 program had refused admission to such an individual, and the other 10 had not yet been asked to admit anyone diagnosed with the disease. Of these 10, three said they would admit based on the individual's

medical condition, three said they would refuse admission, and four stated they had no policy or established guidelines on which to base an admission decision.

The TCs were also asked what forms of AIDS education had been conducted at the programs. All but two of the programs had provided some form of AIDS education to staff and/or residents. Of these programs, most (8) involved both staff and residents in the educational effort (e.g., seminars, counseling, or literature distribution), while 4 involved only their staff.

From the phone interviews it became apparent that a minority of programs had not begun facing either the moral or the practical issues involved in AIDS among IV drug users, particularly regarding TC treatment for persons with AIDS related illness. For some of these programs, the interview process appeared to spur consideration of the issues. The majority of the programs had begun to address the issues, but lacked necessary information and had not resolved the potential value/philosophical conflicts.

Finally, the TCs were asked about what information and services they needed to deal with AIDS. The predominant issues and needs expressed by the 15 therapeutic communities included (1) the availability and dissemination of comprehensive and reliable information concerning the disease; (2) the delineation of a rational admissions policy based on facts; (3) the availability of resources for testing of individuals prior to admission into treatment; (4) the elucidation of issues specific to the treatment of the terminally ill, and (5) the establishment of a TC for the care of substance abusers with AIDS or related illnesses.

Summary

Over the last four years, AIDS has emerged as a major health problem for intravenous drug users, with great impact on persons involved in drug abuse treatment. AIDS is creating many new relationships between IV drug use and death. First, it is increasing the death rate among IV drug users. Second, the long latency period means that an individual may now successfully cease drug use, only to die a few years later. Formerly one could be essentially certain that the health risks from IV drug use could be immediately controlled simply by ceasing to inject. Third, heterosexual and in utero transmission of the virus place the spouses and newborn children of IV drug users at risk of a fatal disease even though they do not inject drugs themselves. Fourth, it is creating demands for types of services, centered around issues of death and dying, that were not previously required in drug abuse treatment. Finally, even though there is no evidence for casual contact or shared living arrangement transmission, AIDS does provoke fears of death among persons associating with IV drug users.

Specific policy questions for therapeutic communities related to the emergence of AIDS are discussed in an accompanying paper. Our review of the epidemiology and therapeutic community experiences with AIDS indicates that spread of the virus is generally well ahead of the development of strategies for coping with the difficult problems that AIDS presents for therapeutic communities. It is apparent that therapeutic communities need to consolidate efforts and resources for coping with the philosophical/value and practical issues related to the epidemic.

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AIDS AND THERAPEUTIC COMMUNITIES: POLICY IMPLICATIONS

Don C. Des Jarlais, Ph.D. & Samuel R. Friedman

Division of Substance Abuse Services
New York, NY

Introduction

The acquired immunodeficiency syndrome (AIDS) is adding new meanings to intravenous(IV) drug use, both for IV drug users and for persons who have never injected drugs. Because the disease is almost uniformly fatal among those who have been diagnosed with surveillance definition AIDS, it generates a level of fear that is much greater than that associated with other diseases common among IV drug users. This fear has led current IV drug users to increase their use of sterile needles in an attempt to avoid exposure to the AIDS virus (1).

Treatment programs in which a client has developed AIDS have undergone great stress over possible transmission of the virus among clients and from clients to staff, as well as over the impending death of program members.

In addition to the practical problems associated with infection control, AIDS raises new policy questions for therapeutic communities (TCs). In this paper we will discuss three policy issues that have arisen as a result of the AIDS epidemic: using (or not using) the antibody tests that indicate exposure to HTLV-III/LAV (the virus that causes AIDS); devising strategies for preventing AIDS among IV drug users; and providing residential treatment to persons who have AIDS. We will also comment briefly on the need for forming working alliances with the other groups most directly affected by the epidemic.

In discussing these policy issues, we will draw both upon our experiences in conducting research on AIDS in IV drug users and upon our observations of the AIDS epidemic in the New York City metropolitan area (which to date accounts for approximately 80% of the cases of AIDS among IV drug users in the U.S (2)). We do not, however, want to create the impression that there is a single set of "right" answers to these policy questions. In many instances the "best" answers may vary according to the individual, the specific program or the specific geographic locality. Furthermore, the processes by which new policies are adopted may be as important as the content of specific policies. Hopefully those affected will participate in, or at least be represented in, the policy deliberations.

Before discussing these three policy issues, several comments on the transmission of HTLV-III/LAV are also appropriate. As noted in the accompanying paper that reviews the epidemiology of HTLV-III/LAV, heterosexual transmission (particularly from male to female) and in utero transmission of the virus both occur. In the United States, IV drug users are the primary sources for these types of transmission (3). While all evidence indicates that HTLV-III/LAV is not spread through any form of casual contact transmission, there is great public concern that the virus might be transmitted this way (4,5). Policy issues regarding AIDS among IV drug users must not only consider IV drug users, their sexual partners and children as potential victims of AIDS, but also public fears of casual contact transmission.

One of the most important aspects of AIDS is the long time period betwen exposure to HTLV-III/LAV and development of the disease. This "latency period" is presently estimated to be about five years (6). Many of the most difficult policy decisions that face TCs are linked to this long latency period. Death has always been a frequent consequence of injecting illicit drugs, but the linkage was close in time. If one had not died from drug use, then stopping would almost certainly guarantee protection against any future drug related death. AIDS breaks this linkage between current behavior and consequences. IV drug users, and those who treat them, must now worry that even drug users who successfully abstain from further drug use may die or transmit a fatal disease to their spouses or unborn children as a consequence of their previous drug use. This potential futility of successful drug abuse treatment is an underlying thread in the first three of the policy issues we will discuss.

HTLV-III/LAV Antibody Testing

Commercial tests for antibody to HTLV-III/LAV are now available, and there is great debate as to the proper use(s) of the test. These tests measure exposure to HTLV-III/LAV, but they do not predict whether or not an individual will ever develop any disease as a result of the exposure. HTLV-III/LAV is generally not cleared from the body, however, so that an exposed person must be considered as probably capable of transmitting the virus at any time after exposure.

There is general agreement that the tests should be used for research and for screening blood donations, and that persons who wish to know their antibody status have a legal/moral right to this knowledge. Areas of disagreement include the extent of counseling that should be provided along with test results; informing sexual partners of antibody positive persons; and use of the tests for employment, educational, or health insurance eligibility decisions.

Since there is as yet no effective treatment for AIDS, knowledge that one has been exposed to HTLV-III/LAV can create great psychological stress. Responses to this stress can include suicidal behavior and increases in transmission related behavior (to take psychological revenge upon those who exposed the individual). Therapeutic communities provide ongoing counseling services to IV drug users at risk for HTLV-III/LAV exposure, and are resources with expert knowledge in counseling drug abusers. The extent to which therapeutic communities should devote counseling resources to IV drug users who wish to learn their antibody status is a difficult question. The answer will likely vary at least in part upon the demand for testing among IV drug users and the availability of other counseling resources.

A particularly complex aspect of counseling regarding the antibody test arises with respect to family planning. The great majority of IV drug users are of child bearing age, and many are actively contemplating having children (7). There is something of a consensus that an HTLV-III/LAV antibody positive woman should postpone pregnancy until more is learned about the likelihood of transmission to the fetus.

A second complex issue in antibody test counseling for a seropositive individual concerns informing others who may have been or may be currently at risk of HTLV-III/LAV exposure from the seropositive individual. This is not a great problem regarding persons who may have shared needles with the target individual, since they presumably already know they are at some level of increased risk for HTLV-III/LAV exposure, and therefore it would be quite difficult to locate many of these individuals. Current sexual partners of an antibody positive individual would be relatively easy to locate, may well not have been already exposed, may be able to take effective measures to guard against exposure (without necessarily ceasing the sexual relationship), and may also wish to know for family planning purposes. Such sexual partners, however, may not know that the specific individual has a history of drug injection. Informing others who may be currently at risk for exposure presents a potentially extreme conflict between the rights of the individual being tested and the person potentially being exposed. Our present recommendation in this area is that the issue of who would be informed should be addressed as part of an individual's decision to be tested.

The question of antibody testing in contemplation of having children also applies when the relationship between the potential father and potential mother is still in an early stage. Romantic relationships frequently develop among residents of TCs, with the intention of marriage after completion of treatment. In this situation, there is the possibility that a resident may want to know the antibody status of a potential spouse. (There have been suggestions that HTLV-III/LAV antibody testing be made manditory as part of obtaining marriage licenses, though it does not look like this will occur soon.) There are no easy solutions to the problems presented when a resident wants to know the antibody status of a potential spouse and that person does not want to be tested, or if testing is done and positive results are found.

A final problem concerning HTLV-III/LAV antibody testing of TC residents involves maintaining the confidentiality of the results. Maintaining confidentiality is legally and ethically fundamental to any successful testing. Even if all standard methods for maintaining confidentiality were used in a TC, however, there would be problems. The emotional impact of an antibody positive result is likely to be sufficiently great enough to be detected in the normal close observation and group encounter sessions within TCs.

Preventing AIDS among IV Drug Users

Strategies for reducing HTLV-III/LAV transmission among IV drug users also present difficult policy choices. As noted in the accompanying paper that discusses the epidemiology of HTLV-III/LAV, prevention of viral exposure among IV drug users would reduce exposure of heterosexual partners and children. Prevention strategies must therefore include consideration of the persons to whom IV drug users may transmit the virus as well as IV drug users themselves.

HTLV-III/LAV is not transmitted through drug injecting in itself, but rather through the sharing of works to inject drugs (8,9). (Transmission may occur sharing of not just the needle, but also the syringe, and possibly the "cooker" used to prepare the drugs for injection.) Persons who are currently injecting drugs may thus greatly reduce their chances of exposure to HTLV-III/LAV by changing from needle sharing to using their own needles and works. They may also reduce the chances of HTLV-III/LAV transmission by cleaning their works in solutions of 40% alcohol or 10% household bleach, both of which will kill HTLV-III/LAV.

There is consistent evidence from New York City that IV drug users will use knowledge about HTLV-III/LAV transmission to reduce needle sharing and increase their use of sterile needles (10). Thus informing drug users about HTLV-III/LAV transmission through needle sharing may lead to important behavior changes to reduce transmission. (Whether informing IV drug users of specific ways to clean needles that kill HTLV-III/LAV leads to adopting these practices has not yet been studied, but must be considered as a possibility.)

Providing drug users with information on how they may continue to inject drugs while greatly reducing the chances of HTLV-III/LAV transmission will be seen by some as a necessary public health prevention measure. Others will see it as counterproductive encouragement of drug use. Information about transmission through needle sharing has been distributed by drug abuse treatment and public health authorities in New York City and San Francisco since 1984. Distribution of a pamphlet containing the same information was halted in Los Angeles because county supervisors believed that it was encouraging drug use (11).

The question of preventing HTLV-III/LAV transmission versus encouraging drug use is relevant not only to distributing information about needle sharing, but also to questions of the legal availability of sterile needles for IV drug users. At present, prescriptions are required for the purchase of hyperdermic needles in only 11 states and the District of Columbia (12). The 11 states include some with high concentrations of IV drug users, e.g. New York, New Jersey, California, Illinois. Other states with high concentrations of IV drug users, e.g., Michigan, Louisiana, do not require prescriptions. Public health authorities in New York are currently considering changing the prescription requirement as a method for preventing HTLV-III/LAV transmission. Much of the discussion concerns the extent to which removing the prescription requirement might encourage drug use, particularly whether it might encourage persons to start injecting who otherwise would not.

As persons with expertise in what does and does not encourage people to inject drugs, TC staff must expect to participate in public health considerations of what information about AIDS should be disseminated to IV drug users and what are the appropiate legal restrictions on the availability of sterile needles during the AIDS epidemic. TCs will also have their own specific prevention situation with regard to persons splitting from treatment. A large percentage of persons entering TCs do split, and staff are often aware of who is about to split. Splittees must be considered at high risk for injecting drugs, and thus for exposure to HTLV-III/LAV. What, if anything, should staff tell a resident about to split about HTLV-III/LAV transmission? How does one balance needs to retain residents until they complete treatment with reducing exposure to HTLV-III/LAV among residents who do split? We do not want to advocate any specific positions on these policy questions, but do wish to make three general comments relevant to AIDS prevention among IV drug users.

The first is that the actual effects of actions that may reduce HTLV-III/LAV transmission and/or may "encourage" drug use are subject to empirical study. There are many myths and stereotypes regarding what does and does not motivate people to begin or change drug use. Conclusions from well conducted studies prior to the AIDS epidemic may or may not apply to the changed situation. Important mistakes could be made with respect to prevention efforts unless appropriate data are utilized in decision-making.

Second, debates over proper prevention strategy are not likely to lead to constructive action unless there is a willingness to recognize the validity of the emotional experiences of persons working with different aspects of the problem. Persons working in law enforcement, drug abuse treatment or prevention programs are likely to have had many personal experiences that convince them of the great need to do everything possible to discourage drug use. Similarly, persons working with AIDS patients will have had intense emotional experiences that convince them of the need to do all possible to prevent transmission of HTLV-III/LAV. Unless there is an awareness and respect for these different emotional experiences, it is not likely that concerned groups will be able to arrive at prevention programs that are acceptable throughout the community.

A third comment concerns the need for multiple approaches to AIDS prevention efforts. Neither IV drug users, nor those at high risk for becoming IV drug users, are homogeneous groups. Different prevention activities will undoubtedly be needed for the different subgroups. The range of prevention activities could include disseminating information about AIDS, the means of HTLV-III/LAV transmission and how to clean needles; increasing the availability of treatment for those who wish to enter; increasing the legal availability of sterile needles for those who do not want to enter treatment; providing antibody testing and counseling for individuals who wish to learn their antibody status; and working with youth at high risk of starting to inject to prevent them from becoming IV drug users.

Residential Treatment for IV Drugs Users with AIDS

A third policy issue concerns housing of current and former TC residents who have developed AIDS. Almost all IV drug using AIDS patients will require an initial hospitalization during the period in which a diagnosis of AIDS is being made. With the increasing ability to treat the clinical manifestations of AIDS, the majority of these patients will recover sufficiently to a point where they no longer need hospitalization. Maintaining such patients in the hospital when this level of medical care is not required is very expensive, and is particularly difficult to justify given the great demands on medical resources that have been created by the AIDS epidemic.

If the AIDS patient had been a resident in a TC, the question of taking the patient back into the TC poses difficult problems. Some of these problems are practical, in terms of providing the level of supportive care that such a patient may need and of maintaining proper infection control. The most difficult problems, however, are in the conflict between handling issues of death and dying for some while also trying to instill hope for a drug free life in others.

The sense of family created within TCs leads staff and residents to want to take back a resident with AIDS, particularly if that patient does not have another place to live. Not to take back such a patient seems a betrayal of the commitments to helping each other that are made as part of life in a TC.

Providing housing within a TC to an IV drug user with diagnosed AIDS, while in keeping with the fundamental spirit of mutual assistance, also poses challenges to the treatment philosophy of TCs. An AIDS patient who does not require hospitalization may not be able to participate fully in the regular activities of TC life. A special TC treatment program, determined primarily by AIDS illness factors, would have to be created for such a resident. This program would be contrary to many of the rules that relate rewards and privileges to behavior within the program, and would have to include special counseling around issues of death and dying.

In addition to the need to create a special program for an AIDS patient within a TC, the presence of a resident with AIDS would also be seen as a contradiction to the sense of hope needed to overcome drug addiction. The presence of an AIDS patient within the program might serve as a constant reminder that successful efforts to achieve a drug free lifestyle may nonetheless be followed by a fatal drug-related illness.

The anti-motivational effect of an AIDS patient in the program may be seen directly through a negative fatalism--"I may get AIDS anyway, so why not go back to doing drugs"--or indirectly. One indirect expression of fear of AIDS is in excessive concerns with casual contact transmission from the AIDS patient. Concerns about transmission from sharing living arrangements are often incorrect on two grounds. All current epidemiologic evidence shows no viral transmission from sharing living arrangements with AIDS patients. The precautions that should be taken to limit hepatitis B transmission are effective in preventing AIDS transmission. In addition, it is the asymptomatic carriers, persons with the virus but without any evidence of disease, who are probably most able to transmit the virus to others. The AIDS patient, identified as having the disease, is a convenient target for displaced fears of AIDS. A progam that does provide residential treatment to an AIDS patient will not only have to provide accurate information on transmission to staff and other residents, but will also have to cope with the fears of all ex-IV drug users that they may develop the disease.

As if the problem of whether or not to take a resident who develops AIDS back into a TC were not sufficiently complicated, there are variations that guarantee additional difficulties. One variation is an IV drug user with AIDS who is not a former resident but does want TC treatment. Assuming that the person's health status would permit some level of participation, and that proper medical support could be handled within the program, should he or she be admitted? The program does not have the same sense of responsibility associated with a former resident, but should TCs take a position that such a person must either enter other forms of drug abuse treatment or no treatment at all?

Policy decisions regarding accepting AIDS patients within TCs must also address patients with AIDS related complex (ARC). ARC can be seen as a milder version of AIDS that may or may not lead to full surveillance definition disease. The problems of special treatment needs, dilemmas for treatment philosophy, and threats to motivation are applicable to ARC patients as well as to AIDS patients. Because there will probably be more ARC patients than AIDS patients who do not require hospitalization, it may even be best to frame the policy decisions in terms of the conditions under which TCs should provide treatment for ARC patients. Decisions regarding AIDS patients could then be logical extensions of policies with regard to the ARC patients.

As a final comment on the policy issues regarding housing/residential treatment of drug users with AIDS or ARC, we should note that these should not be addressed by TCs in isolation. The problem requires coordination with the hospitals that provide the medical care needed by AIDS patients, other drug abuse treatment programs, and community social service groups that attempt to provide a wide variety of needed support services to persons with AIDS related diseases.

Working Alliances

The above comment on the need for coordination with others in the community who are providing services to persons with AIDS related disease leads to the final question that we wish to raise in this paper. This is not a policy issue in the sense of the three previously discussed, but may involve similar processes of value exploration and conflict resolution. Homosexual men are the largest group to have contracted AIDS. They have also taken the leadership role to press for resources for research and treatment for AIDS and have organized a variety of community support services for persons with AIDS or ARC. As the two largest groups to develop AIDS (in the US and in Western Europe) gay men and IV drug users will have strong common interests in a variety of AIDS related issues. These include minimizing discrimination against persons with AIDS and/or exposed to HTLV-III/LAV, as well as research, treatment and support services.

Gay men and drug abuse treatment providers do not come to these new common interests from a background of mutual understanding. Both groups have tended to hold disrespectful stereotypes of the other. The IV drug user subculture has tended to deny homosexual feelings among men, and this has often been carried over into programs that utilize ex-addicts as counselors. The gay subculture has tended to deny the abuse potential of drugs. Ethnic and social class differences between these two groups provide additional bases for misunderstandings. For these two groups to learn to work together effectively will require not only the usual skills of cooperation and compromising, but also personal examinations of fears and prejudices regarding the other group.

Summary

AIDS is not simply another adverse consequence of injecting drugs. The characteristics of the disease, including the high fatality rate, the long latency period, and sexual and in utero transmission, form an unprecedented and deadly combination. Barring an unexpected breakthrough in either treatment or vaccine research, all treatment programs that work with IV drug users must adapt to a new, and realistic, fear of death.

Specific problems that AIDS raises for TCs include using (or not using) the antibody tests, devising AIDS prevention strategies, providing residential treatment to drug users with AIDS, and forming working alliances with others greatly affected by the epidemic. The first three of these require TCs to confront directly the potential demoralization caused by a drug-abuse-caused death that cannot be prevented by stopping current drug use. The fourth will require new cooperative skills and a willingness to examine and revise possible personal prejudices. Some TCs have had to work through these policy dilemmas on a crisis basis. Others have the opportunity for some contemplation and planning prior to a crisis.

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AIDS SAFE SEX GUIDELINES FOR WOMEN

General Guidelines

The AIDS virus is transmitted through direct contact with infected blood, semen, urine, feces, and possibly vaginal secretions. Although the AIDS virus has also been found in saliva and tears, there is currently no evidence that it is transmissible through these fluids. Body fluids can be exchanged through needle-sharing (blood), or through unprotected sexual contact with a person who is infected. Therefore, if you believe that you or your sexual partner(s) may be infected with the AIDS virus, or you are not sure, avoid contact with body fluids.

Specific Guidelines for Sexual Activity

Safe

- Massage
- Hugging
- Body-to-body rubbing
- Social (dry) kissing
- Voyeurism, exhibitionism, fantasy
- Touching your own genitals (masturbation)

Possibly Safe

- Vaginal or anal intercourse with a latex condom
- Fellatio/blow jobs with a latex condom
- Cunnilingus with a latex barrier (see back of page for description)
- Hand/finger-to-genital contact with a latex glove (mutual masturbation, hand jobs/locals, vaginal or anal penetration with fingers)
- French (wet) kissing
- Water sports (external only)

Possibly Unsafe

- Cunnilingus without a latex barrier
- Hand/finger-to-genital contact without a latex glove

Unsafe

- Vaginal or anal intercourse without a latex condom
- Fellatio/blow jobs without a latex condom
- Semen or urine in the mouth
- Blood contact of any kind (including menstrual blood and sharing IV needles)
- Rimming (oral-anal contact)
- Fisting (hand in rectum/vagina)
- Sharing sex toys that have contact with body fluids

IN ANY SITUATION, SEXUAL OR OTHERWISE, SHARING NEEDLES IS UNSAFE.

CAN RECOVERING ADDICTS DRINK?

David E. Smith, M.D.

Haight-Ashbury Free Medical Clinic
San Francisco, California

I have this opportunity as a friend of the therapeutic community movement to speak today on one of the more controversial issues that relates to the therapeutic community movement, namely, can the ex-addict drink? The therapeutic community had its origins in working with the heroin addict at a time when heroin addiction was seen as something separate from alcoholism. It is interesting, however, that the first therapeutic community, Synanon, evolved from an initial experience with Alcoholics Anonymous, which has a separate history and tradition. It was the perception that the heroin addict and the alcoholic were very different, in terms of behavior, in terms of response to drugs. You saw in these separate systems different views, philosophies, even a different language.

In the 80's these separations and differences are becoming progressively more dysfunctional. They start from the street and go right on up to the treatment staff and the leaders of the therapeutic community movement. I want to emphasize that the division does start on the street. When I started in the addiction field 20 years ago at San Francisco General, the heroin addict would point his finger at the alcoholic and call him a "juice freak" and the alcoholic would point a shaky finger at the heroin addict and call him a criminal and a pervert. Alcoholics and addicts don't like each other right from the beginning. It moves up through treatment staff to leadership, with ç the perception that these are very, very separate. In fact, as these different movements have evolved and clearly done an outstanding job dealing with individuals who have addictive disease, there has been a parallel development in the field of addictionology, which is based on the study and treatment of addictive disease. There has also developed a whole philosophy as it relates to inpatient chemical dependency treatment, and there is also a different epidemiology, including a different epidemiology of people who are coming in to a therapeutic community. The vast majority of young people in fact, are polydrug abusers.

The idea that people are drug specific, particularly that young people are drug specific, and will only use heroin, or will only use alcohol, or will just use methamphetamine or cocaine, is becoming a real rarity. The vast majority of young people who are in chemical dependency treatment programs are polydrug abusers. It's becoming clear from the research that if you have an addiction at one time you have a higher possibility of developing addiction of another type. The family evidence is that if you have a family history of alcoholism or other drug dependence, there is a substantially higher probability that the children will develop alcoholism or some form of drug dependence. This is becoming a more important issue because as the therapeutic community movement matures, many people are having children, the children are growing up, and the attitude that all you have to do is stay clean from one drug, or stay away from one drug, is becoming progressively more dysfunctional. A chemical free philosophy is evolving as the best and most effective way to recover from addictive disease of any type.

What I hope to do in the time I have is to briefly deal with the evidence that relates to the disease concept of addiction and then apply that to issues as I have seen them in the therapeutic community movement. Clearly the issue of alcohol in the therapeutic community movement is one of the more controversial ones.

It starts at the streets. We have people that are graduates of therapeutic communities come into Haight Ashbury Clinic and say, "I'm not using dope, heroin, so I don't have a drug problem any more." They're drinking a fifth of whiskey, a couple bottles of wine, their liver's enlarged, they're having drunk driving arrests. In fact, what has happened is that they've switched from the toxicity of one drug, heroin, which is highly criminalized -- you stick a needle in your arm, you have to steal a hundred dollars a day, that's a drug -- to another drug that's legal, and that's manifesting a very different toxicity.

We define recovery as living responsible and productive lives without the use of psychoactive drugs. Drug switching is not recovery. Changing from the toxicity of heroin and the dysfunction associated with heroin to the toxicity of alcohol and the dysfunction associated with alcohol is not progress. That is not recovery. Society may like it more, it tends to underreact to alcohol, even though alcohol in the United States is the third largest killer behind heart disease and cancer and produces more damage, in terms of health consequences, than all of the other drugs combined. But in terms of the health and welfare of that individual, switching from an illegal to a legal drug of abuse is not progress, but rather a way of moving from an illegal drug to a legal drug. In that context, you will also see situations that are quite controversial in terms of the people that are within the therapeutic community itself. I know this is an issue that many of you are debating

at this time. This was reflected in the January-March 1984 issue of Journal of Psychoactive Drugs that was devoted to therapeutic communities. Many of the leaders of the T.C. movement published in this issue.

The introduction was by Robert Frye and stressed alcohol as an internal issue reflecting attitudes of a portion of the TC movement as it was related in the literature. He cites a statement by Herbert Freudenberger which represents the prevailing view of alcohol use in the mid 1970's:

> "Alcohol is an internal issue, re-entry should be viewed as the testing time, a time in which the resident, as well as the program, can evaluate what it has accomplished together. It is during this period the resident should be allowed to drink alcohol, possibly smoke pot, to test themselves on how successfully they can deal with these potential addiction problems. It was thought that the TC concept and philosophy were not sufficient to understand and deal with alcohol problems, and it was thought that the large peer pressure was not effective in controlling drinking behavior. In a few TCs, the question of whether alcohol or pot were permissible was decided by insisting on abstinence. Some gave drinking privileges to senior residents and some permitted controlled drinking in the re-entry stage."

First of all, I want to deal with this attitude. The Haight-Ashbury Free Clinic started as a street clinic. In the early 70s we were offered an alcohol grant, and our staff said, " No, we understand junkies, we are comfortable with junkies, but we don't understand these alcoholics." So we rejected the grant. You see that in the therapeutic community reflected by this literature. They were familiar with heroin addicts. "We understand heroin addicts, but we don't understand alcoholics." To begin with, in the field of addictionology, we've learned that the basic principles of treatment apply to all forms of addictive disease. In fact, the TC movement can be one of the ç most valuable in dealing with the disease of alcoholism, particularly as part of a poly drug abuse problem, if they would have common end points, if they would use their therapeutic modality to focus on abstinence and recovery rather than drug switching. In addition, in the Freudenberger quote it implies that the reason a person has a drug problem is purely environmental. He had the wrong neighborhood, the wrong house, the wrong environment, he had bad grades, he had character problems. That's how he became an addict.

As we understand addictive disease, more and more we're becoming aware that it is the broad formula of "Addictive disease = genetics + environment." There are environmental factors. But we're also becoming aware of the susceptible host, who manifests addictive disease as a consequence of an altered response to the drug. If you have higher susceptibility in the case of one drug, like an opiate, you will have higher susceptibility to the abuse of other psychoactive drugs, including cocaine and alcohol. These two are the ones that I'm finding TC s having the hardest time dealing with, particularly alcohol.

One of the things that's implied is that if you stay in the therapeutic community movement you mature, you correct character defects, and you can go out and drink, because that's the reward of a good life. Responsible people drink alcohol. In fact, I think that's playing Russian roulette with the individual's recovery. What I have seen, personally, are people who have gone into therapeutic communities, have perceived that drinking privileges are a reward for moving up the hierarchy. When they graduate they don't use opiates, but what I've seen are drunk driving arrests and the medical problems associated with alcohol abuse. I've seen them have all the signs and symptoms of alcoholism, including job and family disruption. When I see them, we see real tragedy. With one very prominent graduate of the TC, I testified on his behalf in court because he killed somebody in a drunk driving wreck and his son was drunk in the back seat. He wasn't using heroin, he wasn't sticking a needle in his arm. He wasn't stealing, he wasn't in jail. But his perception that he could drink socially, he could learn to drink in controlled circumstances, totally went out the window when he graduated, and he transmitted this message to his son. Research indicate that the sons of alcoholic fathers have a much higher probability of developing alcoholism or any addictive disease. The evidence is clearly in the direction that once you have addictive disease, it is very high risk to involve yourself with other psychoactive drugs, and in fact the most effective treatment on a long-term basis in a chemical-free philosophy. And, in that context, I think that what happens in some of the therapeutic communities is a form of a controlled drinking experiment.

There was a study done by the Sobels in which they studied the chances of success of converting alcoholics to controlled drinkers. In that circumstance, what happened was they took an alcoholic individual at the VA Hospital who had had a positive tissue dependence on alcohol, and did all sorts of things to teach them to return to the controlled use of alcohol. They claimed is was a great success and published it. I was skeptical at the time because I know that alcoholics spend most of their lives trying to control their drug use as do other addicts. It didn't seem to me that in the VA Hospital they did anything different than the alcoholic had already tried themselves. But they published this, that controlled drinking works for the alcoholic. In the followup study, half of the people had died from alcoholism, and the other half were abstinent. They were able to control the use while everybody was watching, in that tight, structured environment. But when they graduated and went on their own, alcoholism escalated dramatically, the

disease of alcoholism manifested itself, and in fact the controlled drinking experiment was a failure. In a parallel fashion, control in a TC does not easily translate to control in the community.

As the therapeutic community movement has evolved, people graduate. You see them drink in the TC, and they look like they can control their alcohol use. But when they get out on their own, that compulsion, lack of control, continued use despite adverse consequences (which is a hallmark of the addictive process) manifests itself. Just because you see somebody in a tightly structured, highly observed situation temporarily control the use of alcohol does not mean on a long term basis that they will not cross the line back into a very serious alcohol relapse.

In addition, there's a growing body of evidence that if you violate a chemical-free philosophy, in this case with alcohol, it increases your relapse factor of primary drug of abuse. The current research in the brain chemistry of addictive disease indicates that with the alcoholic, an abnormal metabolite of acedaldehyde/isoquinolines interact with the opiate receptors so that with the alcoholic, alcohol may be even acting as an opiate in the brain. That's one of the reasons that individuals that have the disease of alcoholism will manifest an altered response.

In addition, there is some evidence that suggests that the abuse of alcohol can trigger drug hunger and if the drug hunger is conditioned to opiates or cocaine, they will relapse back to their ç primary drug of abuse. We see this all the time in our cocaine recovery groups. "My problem is cocaine, that's what's causing me all the difficulty." They stop using cocaine but when they violate a chemical free philosophy with alcohol, it triggers drug hunger, relapse is set up, and the next thing we know they're in the middle of a cocaine relapse. It is very clear that if an individual abuses alcohol and violates chemical free philosophy, it increases their chances of relapse back to their primary drug of abuse, either opiates or cocaine. I think this message should be given very, very clearly to individuals in the therapeutic community movement.

Now, I would also like to deal with some of the areas of resistance and controversy. Why is it perceived in spite of the growing body of medical evidence to the contrary, that addiction is purely environmental and people who stop being opiate addicts can be controlled drinkers? Why is their such hostility toward people who present the disease concept? I know, for example, when I present the disease concept and cross addiction, very often what I will get is a very negative response. I think part of it is a misunderstanding of the disease concept. The disease concept goes on the assumption that addiction is a pathological process with characteristic signs and symptoms, with a predictable prognosis without treatment. It is perceived in the field of addictionology as the best and most effective treatment for addictive disease are abstinence, recovery-minded treatment strategies that revolve around the group process. Well, that happens in TCs. There should be no inherent opposition to this. Part of it is because, at least the critics in mind, when you say to these doctors, we've accepted the disease concept within the therapeutic community movement, the next thing that's going to happen is that the doctors are going to take over the therapeutic community. Not true! If you define a disease, it in no way says that physicians are the ones to treat that disease. In fact, in my experience, physicians are some of the least successful individuals in treatment addictive disease. Accepting the disease concept in no way suggests that the medical profession, with all of its ignorance, will take over. On the other hand, if you accept that it's a disease, and you do have a physician that is recovery-sensitive and understands the addictive process, it can be a very valuable part of a health care team necessary to deal with addiction.

Beyond the attitudinal issues is an opposition to the disease concept which I think is a misunderstanding of the disease concept, I want to share with you some other issues that have been raised by Frye as regards TCs in opposition to enforcing alcohol abstinence. Despite the fact that the literature indicates that over 40% of therapeutic community newcomers have signs of alcoholism, and in fact may have had serious problems with alcohol prior to entering this therapeutic community, Frye describes the reasons for opposition within the TC movement to an enforced alcohol ban for ex-addicts, graduates, and staff as the following:

1. The realization that most graduates will at some point in time attempt social drinking and a drinking ban would promote secret alcohol consumption and alcoholism.

2. The total alcohol abstinence enforcement policy would prevent open discussion and intervention within the graduate and/or ex-addict staff member who attempts consumption and experiences problems.

3. Relating alcohol consumption to serious illicit drug consumption confuses those graduates who have not experienced problems with alcohol consumption and effectively causes banishment for the alcohol-consuming graduate and prevents possible use of the TC as graduate support and aftercare.

4. A policy of total alcohol as well as other drug abstinence in the graduate promotes a sense of guilt and the drug use of alcohol, leading to possible feelings of failure, low self esteem, low self image, thus facilitating progress from licit to illicit substances and involving a readdiction to the original drug of choice.

5. The policy of alcohol abstinence for ex-addict staff and not other TC staff, including professional staff, is discriminatory and forever locks the ex-addict into the former addict role and paraprofessionalism.

6. Finally, abstinence mandated by administrative fiat can only be temporary. Long term abstinence can only be promoted by consolidating permanent value, life style changes.

Well, again, as you can tell by these TC positions, they go on the assumption that if one advocates a chemical free philosophy, that's a moral position. It's as if I'm trying to tell you, like Carrie Nation, not to drink. We don't present it that way at all. We present alcoholism as a progressive and potentially fatal illness, based on a great deal of education within the treatment program itself.

Now, if the leaders of the TC believe that the reward of progress up the TC ladder is the right to use alcohol, then they're clearly not going to convey an abstinence message to the graduates. One of the things we must deal with, here in the TC conference, is the fact that major and historic leaders of the therapeutic community movement have fallen to the disease of alcoholism. It's not something that we want to publicize a great deal, but it's something that we're all aware of. Now, as you move up the TC hierarchy, if you believe the reward of progress up that TC ladder is the right to drink, then you're going to convey a very wishy-washy, ambivalent, fuzzy message to the TC graduates.

A more comprehensive and contemporary program that relates to alcohol in the TC movement can't just discourage it at the graduate level. It also has to come from the leadership of the therapeutic community movement. And if the leadership of the therapeutic community movement want to hold onto alcohol, you're going to have this inconsistency throughout the program. Again, you must deal with the reality that there have been a number of major and historic figures in the therapeutic community movement that are now at the present time active alcoholics. Some, of course, haven't died of the disease of alcoholism, they haven't died with a needle back in their arm, they haven't died of an overdose or opiate addiction, but they have died of the consequences of addictive disease, or suffered serious dysfunction as a consequence of their addictive disease, in this case alcohol.

I think it is also very important to think about future generations. What we're seeing more and more of in the field of addictionology is, "My father is an alcoholic, I thought I might have problems with alcohol, nobody ever told me about cocaine, I'm a cocaine addict." Or, "My parents had opiate addiction, I was born into it, I thought I might have problems with illegal drugs, I got involved with alcohol, now I'm an alcoholic."

It is considered that although environmental factors are a major force in drug of choice, psychosocial development, type of addiction, there is also the factor of the susceptible host. Although most of the research has been done with alcohol, it is clear that if you have a family history of alcoholism or other drug dependence, there is substantially higher probability that the children will have alcohol or other drug addiction problems. It has to be dealt with as a family issue. It is the concern of all of us that have recovery in our ç families. I've already mentioned some of the evidence that deals with altered response to alcohol early exposure, in terms of some of the biochemical evidence. There are also three studies that have been done in which children that are identical twins born into alcoholic families, were raised separately, it has been found that they had alcoholism initiated at approximately the same age even though they were raised in totally different environments. There was a much closer association between identical twins than fraternal twins in relationship to the onset of the disease of alcoholism. There are other studies now, for example, that are called prospective studies, in which the children, the sons of alcoholic fathers, in comparison to the control, the sons of non-alcoholic fathers, are given their first drink in a controlled situation and the son of the alcoholic father has an altered response to alcohol, right from the first drink. In fact, one of the things that happens is that they are able to push the level of alcohol up to a substantially higher dosage and this looks like a blessing in the beginning. In fact, what appears to happen is that there is a loss of the basic internal mechanism that relates to control. As I mentioned, this loss of control has a biological basis.

Well, what are we seeing? Joe can't be an alcoholic. He drinks everybody under the table. I've never seen him drunk. How can he be an alcoholic. Well, in fact, biological inborn high tolerance for alcohol may be one of the early signs of the disease of alcoholism. If you look back at the early historic AA literature, Doctor Bob, who was one of the cofounders of AA, said "I could always drink more than anybody. The next morning I didn't have nausea. In the beginning I thought that was a blessing. Now I realize that was a curse." That's a very graphic statement from one of the founders of AA as to what we're talking about in science.

Individuals that are addiction prone can have this altered response and some of the perception on the part of individuals that don't understand alcoholism is that they don't have a problem, because they have this high tolerance. They can drink anybody under the table.

This founder of AA also indicated that with his first drink an invisible barrier between he and the rest of the world disappeared. He learned to function better with alcohol. But now he realizes he was an alcoholic right from the first drink. What is the message that is given to TC graduates? Opiates are your problem. If you find that you really like alcohol, that's OK because it makes you more sociable, it makes you a more mature individual, because that's what the real world does. I suggest that that's a very dangerous message. That, in fact, the individual that is alcohol prone will like alcohol better, just like he'll like any other drug better, he'll have a more intense positive experience. And if they learn to like that drug, if they have this altered response, if they perceive a greater sociability and ease of social interaction, then in the long-term what you've done is set the stage for another form of addiction, in this case alcoholism.

In that context, I think it is very important that the therapeutic community movement look at the issue of alcohol, recognize that it is a very important factor in many relapses of TC graduates, it's a very significant issue for the therapeutic community movement, it's a very significant issue in the hierarchy of the therapeutic community movement. It is also an internal issue that puts it in conflict with other movements in the addictive disease field, for example; 12-Step Movement, Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, which is the support system for many TC graduates. You've got a real conflict if in the TC you're being taught the social use of alcohol and you go out and your network involves AA and NA, particularly NA in San Francisco which has a focus on a chemical-free philosophy. You've got a conflict there. You're going to cut that person off from one of the most valuable and important support systems.

I think, also, it is important that the therapeutic community movement educate itself on the signs and symptoms of different forms of addictive disease. I've already described this high tolerance, for example. Given the formula: "Addictive disease = Genetics + Environment" one of the things that we've learned is that alcoholics black out, non-alcoholics pass out. We used to think that blackout was a late stage of the disease of alcoholism resulting from brain damage. Now we know that it's a form of familial alcoholism with a high genetic profile in which the individual will manifest blackout very, very early in their drinking career. Blackout being a period of amnesia in which the individual retains gross motor control. I've been in sessions with TC graduates in which they got drunk and blacked out and nobody said anything about it. A blackout is a pathognomonic sign of the disease of alcoholism. Now that same TC knows very well the signs and symptoms of the disease of opiate addiction, but may not be updated on the current evidence as it relates to addictive disease of other types.

So, in this situation, I feel it's very important that there be an expanded alcohol education program for the therapeutic community movement, starting with staff on down to the graduates. I think it is very important that the TC movement leadership address the alcohol issue and deal with whatever is necessary, including intervention, with those current TC leaders who are actively abusing alcohol. Just because they have made a marvelous contribution to the therapeutic community movement does not mean that you should stand back and allo them to die from the disease of alcoholism. That's not a moral position. That's trying to save somebody's life.

I think that there needs to be a broader and more emphatic emphasis on abstinence from alcohol for some of the individuals in the therapeutic community, and as they graduate and move on to the community as a whole. And in that context that all these elements exist within TCs. I believe that these attitudes that we can't handle alcohol in the therapeutic community modality are more attitudinal rather than based on reality. The therapeutic community movement, the TC environment, with its structure, its setting, its emphasis on the group process, its focus on abstinence and recovery, is well-equipped to deal with the disease of alcoholism. But obviously, new information can not develop unless there is attitudinal change. This attitudinal change has to start within. The first thing we have to deal with is that the reward of graduating from the therapeutic community should not be to die from the disease of alcoholism. The reward of making a major contribution to the therapeutic community movement should not be a switch from opiate abuse to alcoholism. Both the leadership and the graduates of TC, in my opinion, would be best served if TCs evolved toward a chemical free philosophy. In that context, we would have to be very specific with the topic of this presentation. Can the ex-addict drink? That's the question that served as the topic of this presentation. Can the recovering addict drink? My opinion is that the answer is an emphatic no. The TC graduate who holds onto alcohol is playing Russian Roulette with his or her recovery, both in terms of the subsequent abuse of alcohol, and in terms of relapse back to the primary drug of abuse.

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Detox Brew

An herbal infusion of comfrey and mullein aids the detoxification of heroin addicts.

THE Herbalist MAGAZINE

For several years I have been working as a counselor in a drug program for heroin addicts. It seemed to me that many of the older approaches to the treatment of drug addiction were ineffective, so I started using herbs to help addicts detoxify from heroin and methadone.

I have a teapot in my office and usually brew up herbal teas instead of coffee. Occasionally a few of the addicts who I was counseling would express an interest in herbs and we would sit down and drink a cup of herb tea. This started to catch on at the clinic where I work, until in a short while many of the addicts were turned on to herbs.

Of all the herbal concoctions I have used in the past year working with heroin addicts, the most effective and successful combination for detoxification is one I call "detox brew". It is a mixture of comfrey, mullein, rose hips, spearmint, orange peel, and golden seal.

Comfrey is a unique herb with many uses. It aids in healing broken bones, serves as a poultice to draw out pus, and contains a lot of vitamins, minerals, and protein. However, the most relevant of its healing properties is in relation to the tonic to facilitate the healing processes involved in colds, runny noses, or sniffles, which are all common symptoms of detoxification. Since heroin and methadone depress the respiratory system, detoxification entails finding a new balance in respiratory functioning. The comfrey root or leaves in detox brew aids in this.

Mullein is a large plant with fuzzy pastel gray-green leaves. Made into a tea, it is an excellent healing aid for lung ailments such as asthma, bronchitis, or clogged sinuses. It has been used extensively in folk medicine as a home remedy for sore throats, coughs, and ailments of the upper respiratory system. A mixture of comfrey and mullein is effective in re-establishing healthy breathing, especially when addicts are detoxifying from methadone, an artificial narcotic used as

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ALCOHOL & THE TC GRADUATE: THE PERMISSIONS MODEL

Alfonso P. Acampora

Chief Executive Officer
Walden House, Inc.
San Francisco, California

As Chief Executive Officer of Walden House and a staff member over the last 20 years in both an administrative and clinical capacity in a TC I have certain view points on alcohol and the *permissions* that clients take to use alcohol in the final phase of treatment which I would like to discuss in this paper.

I do not believe in the disease model for the drug abuser in the therapeutic community, although I think a lot of people in the United States are following that trend in their treatment modalities now, because of third party payment reimbursement. I truly believe that the alcoholic with alcoholism has an altogether different disorder than the substance abuser who uses heroin, cocaine or other opiates.

I do, however, believe in the permissions model and what I would like to do is to further explore what the permission model is. What I mean by the permissions model is: if you take someone that is in treatment and comes in as a heroin addict with little education and a minimum of social skills, and he participates in your residential treatment center for 18 - 20 months, gets his GED, and is getting ready to re-enter society, go on aftercare services and go on into hopefully becoming a good tax paying citizen, and he walks out of here and drinks, then he is very vulnerable for going back to his drug of choice, because he still has many re-entry issues to deal with and tasks to accomplish.

For example: What do you do on a Saturday night with a paycheck in your pocket? How do you deal with rejection? The whole resocialization issue comes up, and I usually ask "What do you do on a Friday night when you get rejected and how do you deal with that rejection?" You're in a bar and you ask someone to dance they say no. You ask another person to dance and they say no. So you go to the bar and you have 3 or 4 scotches which gives you permission to go and get a half gram of cocaine and ultimately leads to sticking a needle back in your arm. You're not dealing with a substance free re-entry and resocialization when you drink. One permission leads to another, and another, and then you fall.

The same kinds of things can happen working on a job and dealing with the boss. You have a lot of anxiety, starting a new career substance free, taking care of a home. How do you pay your phone bill, gas and electric bill? How do you budget yourself? How do you continue to get some education? How do you put all of these things into your life and lifestyle? I truly feel that during re-entry people are very, very vulnerable to go back ultimately to use their drug of choice and that they should be substance free. They should deal with all of these issues, continue to see our outpatient or aftercare people and work on these issues. Working on re-entry issues is the most valuable piece of treatment that clients have. It's the hardest time. The T.C. is just like a mothers womb. It's warm, secure, comfortable. You meet peers, you meet friends, you get to realize yourself, actualize yourself and when you go into the aftercare component you feel real alone. Its frightening, its a thing that you have never done before.

For example: take a person 30 years old who started using opiates at 13 and missed his whole adolescence. He never learned social skills, work habits, romantic foreplay, job skills and educational habits. He doesn't have any skills - he is a 30 year old adolescent that has to re-learn all of these skills and deal with all of these issues again, drug-free. You give him any kind of substance to use as a cushion, and it ultimately gives him an opportunity to take more permissions, distorts and changes his personality and rationalizations. And with alcohol there is drunk driving, violence, fights and permissions.

I would like to recall a story. My background is that of an ex- heroin addict out of the criminal justice system of New York. When I was in my mid 20's I was tired of using drugs and going in and out of prison systems. I wrote a letter to Synanon and I asked them, (this was 23 years ago) if I could come into their program, and I got a letter back from one of the directors, Reed Kimble, and he told me to get in touch with the Westchester County Parents Association, which I did. They had a weekend of bingo and raised $1,000 to send someone to Synanon, and low and behold, Alfonso was the bingo prize.

After my four year stay in Synanon in the early sixties, I left and became one of the fore-fathers of Delancey Street in San Francisco, California. After a one year stay in Delancey Street, I left and came to work at Walden House, and have been employed in every capacity, from counselor all the way up to the C.E.O. during the last 14 1/2 years.

I would like to recall a time around 10 years ago, when a good dear friend of mine had left Synanon and came to my home with his wife for dinner. At that time I was drinking and I offered him a glass of wine with our macaroni dinner. His hands started shaking, and I asked "What's the matter, John?" He answered, "Well you know, Al, if I drink this glass of wine, I am ultimately going to stick a needle in my arm". Now, there was something definitely wrong with relating a glass of wine to sticking a needle in your arm, especially to someone with an Italian ethnic background. The Italian culture, like most European cultures, has wine and beer at meals and this is part of the ritual of dinner. This is different from the American culture. My friend John said, "I will die" and ultimately he went back to drugs and died.

I think everybody is an individual and there are individual differences in regard to alcohol use and the TC graduate. He needs at least 3 years substance free in his re-entry after participating in Aftercare treatment before thinking about drinking any kind of alcoholic substances. The client that is in the therapeutic community for an 18 month period of time, and has been in aftercare treatment for 6 months to a year should not drink. He needs to experience some of the following things substance free: a relationship, marriage, divorce, separation, a job, up and down the ladder of the job, re-employment, getting his apartment together, getting furnishings together, getting his nest together and is stable in his nest. If he chooses to drink after having done all these things, then that individual should not look at himself as a diseased person for the rest of his life. But he should understand that as a client out of treatment he should not drink alcohol, that this permission could ultimately lead him back into his drug of choice, the criminal justice system or re-cyling back into the therapeutic community.

I do not have exact statistics on this, but I have been working in therapeutic community systems for the last 22 years of my life and believe myself to be an expert academician in substance treatment. I have seen many of my friends fall behind the permissions model alcoholism syndrome, and I've seen many clients that walked out of the T.C. and their reward was to go right out and drink alcohol.

I feel this is an important issue and I want to share this with my colleagues. I have been opiate free for the last 15 years of my life. I drank alcohol for many of those years and I have never abused alcohol. But I can recall several incidents in my re-entry when the alcohol gave me permissions. I'm not saying that Alfonso Acampora will never drink again because I am not a disease model individual. However, I am recommending that if our graduates chose to drink that they do so after a 2-3 year period of time under supervision and individual counseling to clearly monitor behavior and control.

If we would all close our eyes and think about the permissions alcohol can give, I know as a professional in this field, you would agree with me. Thank you very much for this opportunity. I will present further information and research at the 10th World Conference in Eskilstuna, Sweden.

FIRE-WATER: AN ARCHETYPAL PERSPECTIVE

Eduardo Duran, Ph.D.

California School of Professional Psychology
Fresno, California

The Problem

The Native American psyche (soul) has undergone a tremendous wounding process since the Europeans first appeared on the horizon about 500 years ago. Presently, the wound has been searching for relief from suffering by anesthesizing the pain. The most common (and undifferentiated) attempt at healing the psychic wound has been through the consumption of alcohol, i.e., firewater.

The American Indian Policy Task Force has reported that the use of alcohol and other drugs is one of the most serious health problems facing Native American people today. The statistics reveal that nationwide arrest figures for alcohol crimes for Native Americans in 1972 were 12.2 times that of the non-Indian population. Figures for alcoholism also indicate a death rate of 51.9 per 100,000 which is about 5 times that of the non-Indian population. Suicide related to alcoholism is also very high as indicated by a survey among the Papago Indians, which showed a rate of 5 to 10 times the national average. In a report by Nolan (1978), the number for alcohol abuse had increased by 57% in a four year period (1974-1978).

The literature describing the immensity of the problem is abundant but no solutions have been given which have had a meaningful impact (otherwise the problem would be showing an amelioration and as the literature shows the problem is worsening). It is for this reason that this article will suggest some innovative explanations of the phenomenon of disproportionate alcohol abuse among Native people. It seems obvious that in order to heal the psyche (soul) one must search for a soul solution, and the notion of soul is closely associated to myth and myth is inseparable from the land. Therefore, it is rational to search for the soul or psyche in the images, myths, and projections of the gods and demons who emerged from the "native" land as is prescribed by analytic psychology.

Fire-Water as the Image of Conjunction

Present attempts at delivering services to Native peoples are irrelevant for the most part since those services have their genesis in orthodox European theoretical constructs. What the Native person needs in order to heal the problems and illnesses that plague him are conceptualizations of the healing process. For this reason, an affliction such as alcoholism needs to be addressed in a relevant way which makes use of Native symbols, myths, and images.

To accomplish a relevant treatment process the Native individual's traditional way of healing encompassed symbol, myth and ritual. In order to find what the Native psyche needs, one must then address the emerging symbols and images and it becomes necessary to find the meaning of primitive use of symbol to achieve relevance, i.e., unconscious symbols need to be assimilated into consciousness. In order to take a look at the symbolic soul of the Native it is necessary to look for it in places that have myths, symbols, and images available for present examination. To facilitate the search for mythological material, this writer had used material from Meso- America which is literally abounding with catalogued relevant mythological data. From Meso-America the notion of the conjunction of fire and water existed as images projected by the psyche. The most archaic image is that of Tlaloc who is related with water and at times there is also a relationship with fire. The deeper meaning that allowed for Tlaloc to emerge was that of the union of sun and rain in order to produce life on the earth (the conjunction of opposites is obvious). In the fresco Teotihuacan we find Tlaloc as the god of rein with a solar flower emerging from the mouth, and in another image we find the god of fire (Huehueteotl).

The union of opposites is apparent where the god of rain is seen with wings of a butterfly (which is fire) and with these is the symbol of movement and well being (swastika), which clearly indicates the union of opposites. The ancient Meso-American psyche was preoccupied with the notion of uniting matter with spirit, which is the relevance of the above images or myths. This notion is once more clearly seen when on considers the acts of a major divinity in Meso-America, i.e., Quetzalcoatl. After becoming drunk and committing a violation of taboo, he threw himself into the fire and his heart emerged towards heaven (transformation through the destruction of matter).

It has been shown that fire transforms matter in the ancient Native psyche. The trophy that the warrior was after, was the atl- tlachinolli (atl = water, tlachinolli = burnt) which is nothing else than his own soul.

This is such a basic notion that the Templo Mayor de Tenochitlan had the god or rain and the god of fire next to each other on the same pyramid- - there can be no other interpretation, i.e., two acts in the drama of cosmic union. The collective nature of this image becomes apparent when one looks closely at the Shiva Nataraja, which also reflects the union of opposites through the union of fire and water.

Archetypal Ramifications

It is apparent from the above notions that the Native soul has derived meaning from the union of opposites, and that the undifferentiated search for this conjunction may have been one of the reasons why such a psyche is so fascinated by fire-water (alcohol). The dual nature of the conjunction is close to the one found in analytic thinking in the images of the spirit of mercury, who personifies both the diabolical and the holy at the same time. The problem is in the individual identifying the positive side of the archetypal notion and to differentiate this into the conscious aspect of the individual's life.

When the words fire and water are examined it is obvious to see that they stand diametrically opposed to each other. Through the process of fermentation, the opposites are united to form a unity as in the making of alcohol (the fire from the sun and the water used to grow the plant or vine are united in the process of fermentation to produce wine). Therefore, it is apparent that this conjunction may serve as the object of projection for a psyche, which has recently experienced a separation of opposites brought on by a psychic disaster or trauma (such as was experienced in the conquest of the New World.

This separation in the psyche happened in the New World when the conquering peoples overwhelmed the psyche of the Native through the forceful imposition of mythology which was foreign and differentiated in a totally different fashion. While the Native was experiencing a participation mystique consciousness (oneness with the world and a more intuitive form of world view), the Western psyche was experiencing a more rational and technical consciousness (Logos) which stands diametrically opposed to the Native psyche. The Native psyche attempted to regress so as to escape annihilation. In other words, as soon as consciousness becomes too differentiated the unconscious attempts to overwhelm the psyche and return it to a previous state of harmony (where there are no opposites). This notion is clearly demonstrated when one looks at some oral traditions in an analytical way. The Popol Vuh, which is the oldest documented creation myth in the New World, demonstrates clearly that as more knowledge is gained there comes a destruction which attempts to revert the psyche to more primitive psychological state (this notion is also seen the world over in the numerous flood stories- - that is the unconscious overwhelming consciousness).

Since the total regression is impossible, the psyche is left with some of the previous consciousness or ego state. If we were to look at the previous whole of the psyche, then we could see that the previous whole has become split, i.e., part has regressed but part is still left in the conscious ego state.

This small part of consciousness is totally impotent in the face of the overwhelming opposite mythology, and therefore only serves as a place where the individual and collective psyche can remain painfully aware of the overwhelming onslaught of the new mythology which literally rapes the psyche (especially since Western world view is seen as more masculine (logos) by analytic thinking).

It is at this point that the psyche which is still in participation mystique consciousness immediately searches for a material object to project psychological contents onto. Not only will the psyche need a compensatory object, but the psyche will need an object which typifies the long lost conjunction or oneness with the world. The fire-water conjunction offers such an object; complete with the hermetic vessel in which the psyche can become contained as it anesthesizes itself into the illusion of being one with the world once more. Unfortunately, the projection into the vessel is undifferentiated or unconscious which immediately unleashes the shadow side of the compensatory object, i.e., the dark side of alcohol. At this point the psyche is contained in the bottle in what is literally a state of possession, which may require more alcohol to anesthesize the reality of the situation confronted, thus the problem becomes a complete cycle in and of itself.

The fire-water projection remains unconscious and therefore the small remaining consciousness becomes totally seduced and possessed by its own projection. This is made possible in part because while in participation mystique the unconscious is projected onto the object and the object is in turn introjected by the ego, which is what gives the individual the feeling that external object are animated while in this state. Therefore, the fire-water becomes charged with the contents of the unconscious which allows the fire-water to obtain a collective destructive (shadow) potential, which leaves what little ego is left to face annihilation. It is this destructive force that may be partly responsible for the destruction of the Native psyche in the past centuries.

For this reason, it is imperative that the Native psyche reverse the regression that occurred at that time and begin to pursue a more differentiated attempt at the union of opposites. The attempt at conjunction needs

to be congruent with the environment that the psyche confronts itself with, otherwise the psyche will receive yet another wound. It is time that fire-water not be regarded as the source of the problem, but merely as the projected, undifferentiated attempt at restructuring of a fragmented psyche.

An image of a differentiated conjunction that uses fire and water is one of the Plains Indians' sweat lodges. In this healing vessel it can be seen how fire and water are united in order to create the union (steam), which is then used for healing purposes. Not that the sweat lodge is a panacea, instead it may be pointing out that since the psyche had been projecting fire-water as a conjunction, the sweat lodge may have the more positive, healing side of the dualistic process. If the psyche does not discontinue to project undifferentiated contents onto the fire-water, then the tension of opposites will continue to drive the person to the final conjunction, which may be manifested by death as postulated by analytic psychology (this notion may help in understanding the high suicide rate among Native people).

From the images that we find in Meso-America it seems as if the psyche was evolving in a normal fashion in its attempt to differentiate itself into a more conscious ego functioning psyche. The traumatic wound does not necessarily have to be the end of the struggle towards consciousness and the conjunction. It may even be viewed as an event that occurs in the development of nay individual thus allowing psycho-analytic theory to pave the way to the resolution of the fixation.

It seems that the unconscious has given the psyche the clue to the healing process from the beginning. It is no accident that our ancestors immediately coined the devouring fluid in the bottle by the projected image of fire-water. The psyche was at the same time giving the image of destruction, which when seen in the light of ego consciousness can also provide the image for healing and psychological conjunction. The psyche needs to unite the opposites in consciousness instead of projecting the unconscious into the bottle containing the fire-water. This method of healing will require that the mythical layer of psyche be allowed to emerge with its own healing images, as postulated by the analytic process in the works of Jung. If enough individuals can accomplish the union of opposites in a differentiated fashion, then a new collective myth can emerge for the healing of the Indian Nations.

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DESIGNER DRUGS: THE ANALOG GAME

Robert J. Roberton Ph.D.

Department of Alcohol and Drug Programs
State of California

The term designer drugs was originally coined in the laboratory of Dr. Gary Henderson at the University of California at Davis. It was originally meant to refer to the increasing sophistication of chemists in illicit laboratories who are now approaching the ability to produce drugs designed to fit the tastes of individual clients.

Designer drugs are beginning to play a more prominent role in the heroin addict's market place. Fentanyl analogs are being sold as "China White" or "Synthetic Heroin", and are being asked for by addicts on the street. Availability and price are attractive to the heroin user, some who feel they may contain less adulterants than heroin.

Our data collection upon admissions to programs show an alarming increase of approximately 20% in the use of heroin as the primary drug by those 17 years of age or younger. Over 50% of all admissions to public programs in the State of California are for the primary drug of heroin.

Fentanyl

The fentanyls are a class of very potent narcotic analgesics originally synthesized by the Janssen Pharmaceutical Company of Belgium. Although the chemical structures of these drugs are quite different from the opiates and opioids: the fentanyls, nevertheless, possess all the pharmacological and toxicological actions of the classical narcotics. Fentanyl, the parent drug, is used extensively in clinical medicine as an intravenous analgesic anesthetic under the trade name Sublimaze(R) It is a well respected drug.

Beginning in 1979, illicitly synthesized derivatives of fentanyl began appearing on the streets as drugs of abuse under the name of "China White", the name usually associated with very pure Southeast Asian heroin. Soon thereafter a series of deaths occurred in southern California which looked like typical heroin overdose except that toxicological analysis failed to detect any narcotic. To date over 100 such deaths have occurred.

The laboratory at UC Davis, partially supported by the California State Department of Alcohol and Drug Programs, is using very sensitive analytical techniques specific for the fentanyls, and has detected various fentanyl derivatives in the body fluids of the overdose victims. In addition, they have detected the fentanyls in the urine of a significant number of individuals enrolling in various methadone and other drug treatment programs throughout California.

To date they have identified ten different fentanyl derivatives in addition to fentanyl itself in samples being sold illicitly under a variety of names such as China White, Synthetic Heroin and Fentanyl. The newest derivative, 3-methyl fentanyl, is extremely potent (approximately 3000 times as potent as morphine) and is thought to be responsible for an alarming number of recent overdose deaths in the San Francisco bay area.

Fentanyl Derivatives Used Medically

Fentanyl was introduced into the United States in 1968 as an intravenous analgesic anesthetic under the tradename Sublimaze(R) or Innovar(R). Fentanyl now occupies a major place in therapeutics as a preanesthetic medication, an anesthetic, and a post-surgical analgesic. Fentanyl is very potent (approximately 100 times as potent as morphine) and short-acting (duration of action is approximately 70 minutes). It is a very important drug clinically and is probably used in over 70% of all surgeries in the United States.

Sufentanyl is an extraordinarily potent derivative of fentanyl (2000-4000 times as potent as morphine) used as an anesthetic analgesic agent for cardiac surgery. Alfentanyl is a very short acting (15 minutes), slightly less potent derivative (20-30 times as powerful as morphine) currently utilized in clinical trials as an ultra-short acting analgesic to be used in diagnostic, dental, and minor surgical procedures.

Lofentanyl is extremely potent (6000 times as potent as morphine) and very long acting. It is being evaluated for use when prolonged analgesia and respiratory depression are required such as in tetanus and

multiple trauma. Carfentanyl is a very potent analog of fentanyl (3200 times as powerful as morphine) which is used only in "capture guns" for immobilizing wild animals.

The Illicit Analogs of Fentanyl

Very little is known about the biological effects of the illicit derivatives of fentanyl. At best only preliminary data is available from studies conducted in laboratory animals. Virtually nothing is known about their effects on man.

Alpha-methyl fentanyl was the first illicit fentanyl derivative to appear on the streets. It is a very simple modification of the fentanyl structure and is about 200 times as potent as morphine. As a new drug entity, it was not at first on any international, federal or state restricted drug list and was in essence "street legal." However, it is now classified as a Schedule I drug (no approved medical use and high addiction liability) by the Drug Enforcement Agency of the United States.

Para-flouro fentanyl was the second illicit analog of fentanyl to appear on the streets. It is a very simple derivative of fentanyl and has about the same potency. It is presently classified as a Schedule I drug by the D.E.A. Little is known about this compound. It appeared only briefly and does not seem to be in use at this time.

Alpha-methyl acetylfentanyl first appeared on the streets in 1983. This also is a very simple derivative of fentanyl, but because technically it is a new chemical entity, it escapes classification as a restricted drug. At this time it is not a restricted drug. Nothing is known about its pharmacological properties.

Benzyl fentanyl has recently appeared on the streets mixed with other fentanyl derivatives found in samples analyzed by the laboratory at UC Davis. It is possibly an unwanted synthetic byproduct or an intermediate used in the synthesis of other fentanyl derivatives. It has no narcotic effects.

Fentanyl itself has appeared in street samples and has been associated with overdose deaths in California. It is most likely that the fentanyl sold on the streets is synthesized in illicit laboratories and not diverted from pharmaceutical supplies. All fentanyl sold on the streets is in powder form, and all fentanyl sold as a pharmaceutical is in dilute liquid form. Abuse of Sublimaze(R) in hospitals and clinics by medical personnel has been documented but the extent of the problem seems to be known.

3-methyl fentanyl is the latest derivative to be introduced onto the streets and it is certainly one of the most potent of the fentanyls (3000 times as powerful as morphine). This analog appeared in California sometime between the fall of 1983 and the spring of 1984 and is thought to be responsible for over a dozen deaths in the San Francisco bay area, the highest incidence of fentanyl related deaths to date.

Fentanyl and its analogs are cut (diluted) with large amounts of lactose or sucrose (powdered sugar) before they are sold on the street so the amount of active drug present is exceedingly small, less than 1%. These amounts are so small they contribute nothing to the color, odor or taste of the sample.

The color of the samples obtained to date has ranged from pure white (sold as Persian) to light tan (sold as China White, Synthetic Heroin or Fentanyl) to light brown (sold as Mexican Brown). The brown color comes from the lactose which has been heated and has caramelized slightly. The textures of the samples observed in the laboratory has ranged from light and finely powdered to somewhat coarse, cake-like and crumbly, somewhat resembling powdered milk. Occasional samples will have a medicinal or chemical odor, but this is not characteristic.

Intravenous injection is the most common route of administration for the fentanyls: however, they also may be smoked or snorted. In fact, because of their high lipid solubility, the fentanyls should be excellent drugs for snorting and may become increasingly popular among cocaine users. At least one overdose fatality was identified in which snorting was the only route of administration. We have also been able to detect fentanyl in the urine of individuals who used the drug only by smoking it.

In summary, the fentanyls appear in all the various forms that heroin does and there is nothing characteristic about the appearance of any sample that will identify it as fentanyl.

Pharmacological Effects

It should be remembered that although the fentanyls are chemically quite distinct from other narcotics such as morphine, heroin and methadone, they are pharmacologically equivalent; that is, they have all the

effects, side effects and toxic effects of the classical narcotics. Therefore, all the actions of the fentanyls can be reversed by naloxone, although higher doses of this narcotic antagonist may be required.

The euphoria or "rush" from the fentanyls should be qualitatively similar to that of heroin and the intensity of the effect would depend upon the dose and the particular derivative used.

Profound analgesia (absence of pain) is a characteristic of all the fentanyls. As little as 50 micrograms of fentanyl will produce analgesia while only 3 micrograms of the 3-methyl derivative would be required.

Respiratory depression is the most significant acute toxic effect of the fentanyls. The depth and duration of respiratory depression will depend on the dose and the derivative used. However, compared with other narcotics, this effect is relatively short-lived. For example, following 200 micrograms of fentanyl given intravenously, maximum depression occurs within 5-10 minutes, and normal respiration returns within 15-30 minutes. The narcotic antagonist drug naloxone, whose trade name is Narcan(R), is the antidote of choice for respiratory depression and other side effects produced by the fentanyls.

Fentanyl also produces a dose-dependent decrease in heart rate of up to 25% with a parallel drop in blood pressure of up to 20%. This effect is thought to be due to vagal stimulation and can be blocked by atropine. The role of this response, if any, in overdose deaths is not known.

Muscle rigidity, particularly in the chest wall, sometimes called "wooden chest" is a response common to high doses of all narcotics. Individuals using the fentanyls may describe this effect as a muscle tightness or tingling.

The fentanyls produce both tolerance and physiological dependence following repeated administration. Controlled studies have shown that addicts perceive fentanyl as having heroin-like effects. In California, we have found many individuals enrolling in methadone treatment programs who have only fentanyl in their urine upon admission, yet are convinced they use only very high grade heroin. Therefore, when pharmacologically equivalent doses are used, most users probably cannot differentiate between heroin and the fentanyls.

Abuse Potential of Fentanyl

Fentanyl as a pharmaceutical drug was always thought to have a low abuse potential because of its short duration of action and its restricted availablity. Also, it is available only in injectable, aqueous formulations containing either 100 micrograms or 500 micrograms per vial. These relatively small amounts and low concentrations make it difficult for an addict who has reached a level of tolerance of opiates to administer a euphoric dose conveniently.

Until now, the only documented illicit use of fentanyl was in "doping" race horses. Narcotics are frequently used to dope horses because they produce excitation in the horse (and other animals such as the cat and mouse). Fentanyl's short duration of action and its very low, difficult to detect concentrations in blood and urine make it an ideal doping agent. Fentanyl has been used in this manner for nearly a decade.

Now the fentanyls are available throughout most of California and because they are potent, not detected by routine analytical methods, and, in the case of the newer analogs, quite legal, they may become the drug of choice for many heroin users. It is our opinion that fentanyl use will increase in California, its use will spread to other states, and that new derivatives will appear periodically.

Overdose Deaths

To date the laboratory has identified 100 overdose deaths caused by the fentanyls. Nearly all of these cases occurred in California. However, two recent overdose deaths in Oregon suggest that fentanyl use may be spreading to other states. All cases were similar in that they involved known heroin users, injection sites and accompanying paraphernalia. Autopsies showed typical signs of narcotic overdose such as pulmonary edema and congestion. Routine toxicological analysis of the body fluids revealed no narcotics, sedative or stimulant drugs present. However, analysis of these fluids in the laboratory using methods specific for the fentanyls revealed very low levels of these drugs. Traces of the fentanyls were also found in the accompanying paraphernalia.

Fentanyl-related deaths have occurred in nearly every urban area in California, in suburban areas, and even in semi-rural areas. Ages of the victims ranged from 20-49 years. Most were male, although 9 were female. Most of the victims were white, but there were significant numbers of hispanics and blacks. In

short, fentanyl use is not confined to any geographical area or any social, economic or ethnic group, but is distributed widely throughout the heroin using population.

The fentanyls are very difficult to detect either in body fluids or paraphernalia because the amounts present are very small and because they do not react with the reagents routinely used for the analysis of narcotics.

A New Public Health Hazard

There are several clear-cut reasons. First, these drugs do not require importation and all the costs and expenses thereby incurred. Secondly, they are much less expensive to make. Thirdly, of course, those making and selling synthetics may not be prosecuted because the substance may not be illegal. Fortunately, the D.E.A. has recently been able to take swift action to control some of these substances. Let me give some examples. It is estimated that a single chemist working an eight hour day could, using the more potent fentanyl derivatives, supply the entire nation's heroin supply on an on-going basis. A single 6 month supply for the United States could be stored in a closet. Hence, one can see the immense attractiveness of this approach in terms of cost and liability to those on the production side of the illicit drug market.

What are the hazards? There are three basic hazards. First, these chemists are obviously not required to carry out safety trials with these new compounds as a legitimate drug company would. Hence, the first subjects to receive the new chemical compounds would not be laboratory animals, but human beings on the streets of our cities. Secondly, there are no quality controls in these laboratories as there would be in a legitimate drug company. Hence, contaminants or unwanted compounds are not removed, and probably often not even detected. Thirdly, there is the issue of potency. The fentanyl analogs, for instance, must be cut in microgram amounts. This is a tiny amount; a postage stamp weighs about 60,000 micrograms. Hence, overdoses are common, and the fentanyl series has been held responsible for at least 100 deaths in California so far. In essence, young drug abusers who take these new synthetics are playing Russian roulette. Only it is not lead bullets that they are aiming at their brains, but chemical ones.

Parkinson's Disease Side Effects

Given this scenario, one would predict it was only a matter of time before a true poison hits the streets. This is precisely what happened in northern California in 1982, when a highly toxic compound known as MPTP was circulated. This compound is neurotoxic to a group of cells in the brain known as the substantia nigra. By pure coincidence, this happens to be the same area that is damaged in Parkinson's Disease. We saw a group of young adults two years ago come to the Santa Clara Valley Medical Center who resembled in every way elderly patients with end-stage Parkinson's Disease. These young addicts had literally frozen up overnight, and were totally unable to move or talk. Treatment with anti-Parkinsonian therapy was probably life-saving in three cases. However, these patients continue to be severely disabled and require medication every one to three hours just to be able to move and eat or drink. Two of them have recently undergone prolonged hospitalizations and the outlook for their futures must be considered extremely grim.

While there are currently only 20 severely involved young adults who have been permanently crippled by this first "designer drug disaster", we have now identified an additional 500 people who were exposed to MPTP thinking it was a new "synthetic heroin." My estimate is that we have just been scratching the surface so far, and that there are at least one to two hundred more. Why are these additional individuals important? Because we now have evidence that damage to this area of the brain, even if it is not enough to cause symptoms at first, may act like a time bomb, with changes in the brain slowly ticking away. In other words, sooner or later, these young adults could come down with a Parkinson's Disease-like state. Up until now, this concern was just theoretical. But in the last several months, we have started seeing a group of young people at Santa Clara Valley Medical Center who used MPTP two years ago and who are just now starting to develop a myriad of symptoms, all suggestive of early Parkinson's Disease. In short, what we may be facing is an epidemic of Parkinson's Disease in young adults in northern California as a result of this catastrophe. The cost to society, not to mention the human suffering, could be immense.

I bring this entire phenomenon to your attention for a number of reasons. First, I see it as a tremendous potential hazard in terms of dealing with and combating the drug problem among our youth. Ways to deal with this phenomenon and hopefully slow or stop it must be studied now. Secondly, the costs in terms of a public health hazard have now for the first time become clear with this first designer drug disaster. The Parkinson's cases may only be the first wave of drug abuse to cross over from current treatment modalities to full, long term inpatient or maintenance type medical care. The cost of treating severely afflicted patients may see medical costs skyrocket to between $10-20,000 per month depending on the individual case. Thus, the medical economics of designer drug use is another dilemma that government must confront.

We need help and assistance in dealing with what may be an on-slaught of young people with progressive neurodegenerative disease as a result of this. Further, it seems extremely important to study and try to understand this first catastrophe with the ideas of developing techniques and ways to deal with future ones which almost surely will occur given the popularity of this new approach. We have already discovered at east one patient who has an entirely different neurological syndrome characterized by movements closely resembling Huntington's Chorea which have completely disabled him. there are also reports that there is a new PCP "designer drug" which is toxic as well. While traditional street drugs pose a major public health problem and need to be dealt with, I believe this is an instance where attention to a developing and potentially even more serious phenomenon is fully warranted now to prevent a much greater problem in the future.

Summary

Economic and social costs must be considered an important part of all discussions regarding synthetic drugs, especially because some of these drugs, like MPTP, can cause neurodegenerative diseases. Many of these patients require frequent hospitalization including intensive care became of the need to stabilize through therapeutic doses of medication.

Some of them, the more severely affected, will require long term and constant nursing supervision, a most costly endeavor. We cannot escape the irrefutable fact that we have before us, a problem of serious medical and economic gravity. Significant costs will obviously arise from needed law enforcement and treatment programs as the problem's severity intensifies.

The training needs for both law enforcement and the treatment network must be addressed immediately. Without appropriate training these institutions cannot mitigate this emerging problem.

Laboratories play an essential role in our ability to detect the fentanyl analogs in urine. Currently, we have only one laboratory in California with the expertise to do this. Under the guidance and supervision of Dr. Gary Henderson at the University of California, Davis, work has continued for the last four years to establish a routine test for the analogs of fentanyl. Most laboratories can test at parts per million. With fentanyl testing we are talking about parts per billion in body fluids, hence the difficulties. The State of California's Department of Alcohol and Drug Programs will continue to support this work which is of national importance.

I would state emphatically that the use of fentanyl analogs is already spreading throughout the United States. Until we have a network of more sophisticated laboratories, we will not be able to track or understand the scope and magnitude of the developing problem.

The domestic production of new, potent synthetic drugs will be the major drug abuse problem in the future. As efforts to control natural products such as opium, coca and marijuana become more successful, and as safeguards to prevent the diversion of pharmaceuticals become more effective, there will be more incentive to the illicit syntheris of drugs like fentanyl. New synthetic drugs will appear which will be more potent and more selective in their action. Smoking and snorting these drugs (routes of administration difficult to detect) will become more popular. The use of the new synthetics will spread to other states and countries.

The low riak of detection of designer drugs will stimulate their use in populations such as prisoners, parolees and military personnel. Less sophisticated laboratories will attempt to make fentanyl derivaties, thus increasing the possibility of toxic by-products. In addition, it is predicted that families of other drugs of abuse like cocaine and the hallucinogens will be synthesized and appear on the streets. In short, in the future, drugs of abuse will be synthesized domestically from readily available chemicals.

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[redacted]

United States Senate

COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510

July 11, 1985

Alfonso Acampora
Executive Director
Walden House, Inc.
815 Buena Vista Ave. West
San Francisco, CA 94117

Dear Mr. Acampora:

Thank you for inviting me to the 9th Conference of the World Federation of Therapeutic Communities. Unfortunately, my schedule will not permit me to attend this auspicious event.

Since I am vitally involved with families, children and the problems of drugs and alcohol, I commend the Conference for hosting this extremely significant event and worthwhile endeavor. It has also not escaped my notice the wonderful work being done in these areas by your facility. The State of California can consider itself fortunate to have a Walden House in its midst.

Congratulations to the World Federation of Therapeutic Communities. I wish success and know the benefits to be derived from this get-together will be immeasureable.

Sincerely,

Paula Hawkins
United States Senator
Chairman, Subcommittee on Children,
Family, Drugs, and Alcoholism

PH/rlp

TREATMENT OF COCAINE DEPENDENCE WITHIN THE TC SYSTEM

Joan Ellen Zweben, Ph.D.

14th Street Clinic
Oakland, California

Introduction

The treatment of cocaine dependence is perhaps the hottest topic in drug treatment in the United States today. The continued escalation of use on the part of the general public and the dramatic increase in clients seeking treatment has made new demands on our treatment systems. Drug and alcohol treatment providers alike are focussing their attention on what needs to be incorporated into their existing programs to meet the specific needs of these clients. In addition, the conversion of large segments of the South American economy to cocaine production and the development of strains of the plant which mature faster and can be grown in more diverse geographical areas, has led to a continually increasing production which in turn stimulates the search for new markets (Cohen, 1985). Consequently, treatment providers can expect an increase in the number of clients presenting with cocaine as their primary problem.

Areas of this country and the rest of the world which do not now experience much of a problem may well see a dramatic change within the next few years. Across the United States, therapeutic communities have seen an increase in admissions for cocaine as the primary drug, and economic factors alone would be sufficient to produce this same situation in countries currently less affected. Since a well run therapeutic community often comes to be viewed as "the expert" in drug treatment within a community, it is not surprising that both users and those concerned about them are turning to these programs for help. Programs that can respond to their needs not only have an opportunity for a creative challenge, but also a chance to broaden their funding base at a time when tax dollars are steadily disappearing.

Cocaine users present an interesting challenge to the therapeutic community system, because there is a large subgroup among them with somewhat different characteristics than have appeared in the past. Addressing their needs requires that we distill the effective elements in the treatment process and combine them in new ways. The two most significant areas of focus are shortening the length of the residential stay, and strengthening the oupatient components of the program. There is reason to think that the length of stay in the residential stage of treatment can be different for many of these clients, and that outpatient services need to be enhanced to increase effectiveness.

Old and New Populations

Some of the clients admitted for cocaine problems share a very similar profile to those whose primary problem is with opiates. Often, these are dealers, or people who derive most of their income from dealing; people who have lost their jobs and do not have particularly marketable job skills; polydrug users with a preference for cocaine. A high degree of enmeshment in the drug culture and a relative absence of adaptive resources are major determinants of the degree of rehabilitative effort which will be necessary. Such clients are entirely appropriate for the long term commitment required by the majority of programs.

A second population has emerged with different characteristics from those previously seen in large numbers in the therapeutic community. This population has been described by Mark Gold and others from data collected from the national cocaine hotline, 800-COCAINE. Although this sample is skewed (one can speculate that non-white, non-middle class users would be less likely to use a national hotline), it does offer a picture of a newer population now seeking treatment. This group is making increasing requests at a wide range of programs: short term inpatient programs formerly devoted entirely to alcohol treatment, outpatient alcohol and drug programs, and residential therapeutic communities.

As described by Gold (1983), these users were on the average age 30, with an average of 14.5 years of education. They were employed, though many reported job problems, with an average minimum legitimate income of $25,000 per year. Most had never been arrested for anything, but reported "turning themselves into criminals" to support their habit. More than 25% reported they had stolen from family, friends, or their workplace to support their cocaine use. Many sought jobs in which it was easy to steal, or turned down promotions to remain in a position where stealing was relatively easy.

More recent hotline information supplied by Gold (U.S. Journal, May 1985) indicates a slight downward trend in age and income level and some troubling data about the use of cocaine in the workplace. In his recent sample, 75% reported they regularly used at work, with 48% reporting they sold or distributed cocaine

at work; 64% believed the quality of their work was poor due to cocaine, with 18% admitting having job accidents due to use. A sizeable proportion, 39%, feared the health effects of a raise or promotion. Thus it is not surprising that Employee Assistance Program (EAP) referrals are common, with emphasis on short term stays and rapid return to the work situation.

When is Residential Treatment Appropriate?

Cocaine use often produces such a dramatic family and/or job related crisis that it is not surprising that many assume some form of inpatient or residential treatment is mandatory. However, the rate of relapse after the short term hospital programs appears to be very high, for reasons which will be examined later. In addition, many, if not most clients who still have their jobs will be unable or unwilling to make a commitment to a one year residential program. The appropriate treatment response may well be for therapeutic communities to offer a continuum of care, with the possibility of a relatively short term stay (30-90 days), and an intensive outpatient model either as phase II or a complete treatment. In such a model, the client could participate daily in outpatient activities, including education, family work, and group counseling. Even when the client has been through the residential settings, the key to reducing the rate of relapse may well lie in providing multiple weekly treatment contacts and an enhanced support system during the first three months in which the client re-enters the setting in which the triggers and stressors are present. It is this more highly developed set of outpatient services that therapeutic communities have the potential to offer, but do not now generally provide. Structure appears to be the key ingredient in successful drug treatment despite variations in our individual theoretical persuasions. The challenge of outpatient treatment is to create that structure, which is based far more on voluntary compliance in the outpatient setting. This paper will focus in some detail on what this outpatient model needs to include.

An extended stay in a protected setting is under certain circumstances a necessity, and in this context it is important to assess whether a medical (hospital inpatient) facility is advisable. In many cases, it is not the medical intervention but the protected setting which is sought, and therapeutic communities certainly can provide that at considerably lower cost. Some form of residential treatment is appropriate to consider in the following situations.

1) Client is homocidal or suicidal. Many cocaine users feel suicidal and the clinician must carefully assess the level of risk, and the quality of the support system if outpatient treatment is being considered. More will be said about a support structure for outpatient later.

2) Client is acutely psychotic. The cocaine-induced psychosis clears quickly once use is stopped, and some programs may be able to handle this on a short term basis, with clients in whom there is no history of psychiatric disorder.

3) Multiple drug dependencies. If these involve heavy sedative use, a medical setting may be appropriate. If the client has been a heavy alcohol user, with a history of delerium tremens in previous withdrawal episodes, a medical assessment is a must.

4) Client has a history of multiple outpatient treatment failures.

5) Client is incapable of combatting drug hunger on an outpatient basis, and it is necessary to eliminate access for a period of time.

Under these circumstances, a period of time in a residential setting can play a very important role. However, when the stay is short term, it is important that this period be viewed as the launching platform for a long term recovery process, rather than the occasion on which some magical transformation will take place. The disappointment in short term inpatient programs frequently stems from their failure to fulfill unrealistic expectations, rather than shortcomings in their actual offerings. The very term "aftercare" reflects this. Outpatient services which follow the residential experience are frequently viewed as something tacked on after the main event, and many clients assume their participation is more optional, especially if they feel they "did well" in the inpatient program. One must certainly ask if it is not the failure of the inpatient programs to provide more individually-tailored support in the post-residential stage of treatment, which accounts in large part for the high relapse rate. Therapeutic communities share a similar vulnerability. The longer residential stage is an advantage in separating the person from a drug using environment, but this also serves to insulate the client from triggers and stressors, and thus foster a false sense of security. With the traditional population served, it is appropriate to work towards removing the client from the drug using environment, which often involves predominantly criminal activities. With the newer population, however, one is often faced with highly skilled. Possibilities of job transfers are limited when people have highly developed technical skills, and such transfers by no means guarantee a drug free environment. Hence the problem of dealing with frequent temptation needs to be addresed.

II. Psychological/Interpersonal

A.) Clients are urged to make out a detailed schedule of activities which includes exercise, therapies, support groups, etc. The goal at this time is ten drug free days.

B.) Clients are urged to line up their support structure, especially their non-using friends, and make clear to them what they are trying to do and what they will need. They are also urged to create some peer pressure to reinforce abstinence by announcing what they are doing, placing bets, etc.

C.) Clients are urged to list their hazardous situations, and problem solve with their counselors about these.

D.) Urinalysis can provide a powerful support structure in helping a client remain abstinent. Clients make a contract to give urine only if they are drug free. (Full screens are used for this.) Urine schedules appropriate to their drug(s) of choice are worked out with the counselor. This helps restore compromised credibility.

E.) Clients may make a list of consequences if they do not stay free. These need to be specific. For example, the client makes out donations to the IRS which get mailed upon result of a positive result. High stakes contingency contracting (e.g., letter to licensing boards) should always be done in collaboration with a supervisor or agency manager.

F.) Clients are asked to check out 12 step recovery group meetings until they find a group they like. Counselors need to be attentive to resistances to using this support system. AA groups may be preferred over NA or CA groups in a particular community. It is useful for the program to keep track of feedback on this subject and make recommendations accordingly.

G.) Clients are encouraged to identify leisure activities they used to enjoy without drugs, or ones they always wanted to explore. Cocaine users often describe a somewhat subtle flattening of affect that lasts long after the obvious "crash" during the initial period of abstinence. They need to be reassured that this is common, can be modified with exercise, and that their capacity for pleasure will gradually return.

Establishing and Consolidating Abstinence

This stage of treatment overlaps with the first, and begins in earnest as soon as the client has become sufficiently drug free for issues to be meaningfully addressed. Achieving abstinence can be viewed as a psychoeducational task, which involves understanding the how and why of abstinence, short and long term physiological effects of drug use and withdrawal, dealing with drug hunger (Zackon, 1985) and accepting the identity of a recovering person.

The two most common resistances are the tendency to downplay the importance of abstinence from the secondary drugs the client has been using, and the tendency to withdraw energy and commitment from the recovery process prematurely. Clients who consumed alcohol or other drugs without problems prior to their cocaine use are sometimes inclined to rationalize their continuing use of these drugs. Any use during the vulnerable period of early recovery has the potential for undermining judgment, often leading to a slip back into cocaine use. In addition, clients often develop severe problems with their secondary drugs, but their denial mechanisms are at this time so highly developed that this passes unnoticed. Marijuana and alcohol seem to inspire the most adamant resistance; marijuana because it is still frequently seen as harmless, and alcohol when it has not appeared to be a problem in the past. We recommend the client make a commitment to abstain from the use of all intoxicants, not just illegal ones, for a period of six months, which generally provides enough time to assess the issue more thoroughly. Resistance to making this short term commitment can much more easily be handled as ambivalence about the recovery process in general, as most clients view it as a sensible practice. Our long term recommendation to people is that in view of the mounting clinical data on cross-addiction, total abstinence provides the widest margin of safety, but this is much more readily accepted by clients in the later stages of recovery.

Cocaine is a short acting drug, and it is remarkable how rapidly clients begin to look better and return to normal functioning once they become abstinent. It is this very phenomenon that appears to make it easier for them to conclude they have the problem resolved and do not need to continue to invest time in activities connected to the recovery process. However, cocaine users describe a very similar pattern of episodic flareups of craving and early withdrawal symptoms as alcoholics. The risk of relapse is particularly intensified at this time (Erlich, 1985). Involvement in a cocaine recovery group can be invaluable at this point.

Such a group fosters early identification of warning signals and useful strategies for coping. Like family work, it is a crucial part of treatment.

A major task of this stage of treatment is making the major life style changes needed to support abstinence. The longer the client has been absorbed with cocaine use, the more extensive the task of regenerating a social and support network of non-users. When cocaine use is intimately tied to the workplace, this endeavor can be even more difficult. Clients usually encounter a fair amount of negative feelings about their behavior during their drug-using periods. Taking responsibility for this without self-recrimination is a delicate task. Urinalysis can be particularly important for restoring credibility with intimates at this phase. It relieves anxiety on the part of significant others and protects the client from the discouraging experience of being mistrusted even when doing well.

Relapse prevention is an important part of the work at this stage. In conjunction with a research project, Alan Marlatt and Terence Gorski worked out a classification system of situational and emotional factors present in relapse episodes. Previously, programs avoided discussing relapse, in part out of a desire to avoid sending failure messages to the client. When clients are asked about what precipitated a relapse, their responses fall into three categories: 1. negative mood states, such as anger, boredom, and loneliness; 2. interpersonal stress, such as arguing, being criticized; and 3. social pressure situations. By examining the relapse in detail, clients can be helped in identifying specific vulnerabilities, and problem-solve around them. In addition, clients are encouraged to distinguish between a "slip", one use, and a relapse, a continuation of use. Resistances to reaching out for help are very important in confronting these issues. Cocaine recovery groups are an ideal place for this exploration to take place, as other group members are adept at identifying triggers, actions reflecting a set-up for use, and strategies for overcoming these difficulties.

Psychological Exploration

Drug treatment is often mistakenly characterized as not dealing with psychological issues until very late in the recovery process. In fact, the skilled clinician will be using psychodynamic savvy at every stage in the process; however, the focus or goal will be more circumscribed than in insight oriented therapy. It is generally considered appropriate to tackle highly charged psychological issues in earnest only when abstinence is very solidly established. This includes problems of developmental arrest, particularly in clients with a long history of drug use, and the relationship between intolerable psychological states and addiction. It also includes work on traumatic events such as incest, child abuse and molestation, and other forms of brutalization. These will of course come up early in the treatment, but serious attempts at resolution must be postponed in order to be effective. Although the client may continue this type of work with a conventionally trained mental health therapist, an understanding of substance abuse issues is greatly advantageous because of the increased danger of relapse during this kind of work, particularly if the therapist's sense of timing is not finely tuned.

In summary, programs that wish to address the needs of the newer cocaine using population seeking treatment need to focus their creative efforts on the outpatient phase of treatment. In this model, the inpatient stage is seen as the launching platform for the recovery process, rather than the time period when the major transformations will occur. The task is to find ways to build structure in the outpatient treatment, adequate to the changing needs of recovering clients. By so doing, programs will enrich their offerings to their existing components, and most likely improve the potential of a long term successful outcome for everyone.

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HERBS AND ALTERNATIVE HEALTH IN THE TC

Ethan Nebelkopf, M.A.

Walden House, Inc.
San Francisco, California

The use of herbs is a fascinating phenomenon in the treatment of substance abuse. Herbs are natural botanical substances which have noticeable effects on the human organism. Throughout the history of mankind, herbs have been eaten for nutritional and healing purposes as well as for getting high (Nebelkopf, 1981).

The practice of healing with herbs is an ancient art. The earliest treatise on herbalism was written in China over 5000 years ago. In ancient Greece, Hippocrates, who is regarded as the father of modern medicine, wrote extensively about herbs and their applications to medical treatment, particularly in conjunction with diet, fresh air and physical exercise. During the Elizabethan period in England, herbal medicine reached a peak from which much of our present-day herbal lore derives. With the discovery of the New World, it was recognized that the native Americans practiced an herbalism in which the relationship between people and plants was deeply rooted in spiritual concerns. In America during the early nineteenth century, European and Native American herbology combined into an eclectic naturopathy which was widely utilized by lay practitioners (Bliss, 1985).

Following the Civil War and the laboratory synthesis of morphine, professional medicine began its dependence upon advanced technology, particularly laboratory produced chemical drugs. This practice is standard operating procedure in the medical community today, although some inroads have been made in light of the newly awakened interest in holistic health and the new herbalism (Nebelkopf, 1979).

There are herbs which can replicate the effects of most commonly used psychoactive drugs. Herbal "uppers" include guarana seeds, cola nuts and yerba matte, which, like coffee, contain high concentrations of caffeine and act as potent herbal stimulants. On the other hand, there are herbal stimulants which do not contain caffeine (e.g. ginseng, gotu kola, sassafras, sarsaparilla), but which do have definite stimulant effects on the nervous and circulatory systems without the negative effects of coffee.

In addition, there are herbal "downers" which include valerian root, hops, skullcap and chamomile. Valerian root is a very powerful herbal tranquilizer and nerve tonic. Hops are a major ingredient in beer and are relaxing in their effects. Chamomile is an old-fashioned home remedy for cranky children when made into an herbal tea. Relaxo Brew, is a non-addicting relaxing tea helpful in cases of insomnia. This blend consists of valerian root, chamomile and spearmint.

Herbs have proven effective in aiding detoxification from drugs like methadone and heroin. From a holistic point of view, the "getting sick" which an addict experiences during withdrawal is actually the first step in the process of healing. The symptoms of detoxification reflect the active changes the body is going through in order to find healthier balance. Opiates depress the respiratory system and heroin addicts report that they don't normally get colds while they are strung out on opiates. However, once the addict begins the process of detoxification, all of the symptoms which have been suppressed for so long by the opiates begin with exaggerated effect until the bodily systems achieve a new balance. The emergence of such symptoms as colds, runny nose and diarrhea dramatically point out that healing is taking place (Nebelkopf, 1981).

There has been some success in using herbal teas to combat the symptoms of detoxification and to promote healing. Detox Brew is an herbal tea blend consisting of comfrey, mullein, spearmint, rose hips, orange peel and golden seal. It acts as a tonic for the respiratory system for addicts who are detoxifying from methadone or heroin. Comfrey and mullein are old folk remedies for respiratory disturbances. Golden seal is a tonic for the liver and kidneys in helping to eliminate toxins from the bloodstream. Rose hips and orange peel are high in vitamin C, which is helpful in detoxification. Spearmint is mildly relaxing and has a pleasant sweet taste.

The ways in which humans relate to plants and herbs is just beginning to be understood. Drug addicts/users may be said to assign "magical powers" to their favorite herbs on an unconscious level. The heroin addict may "worship" the opium poppy. The cocaine addict is enamored of the seductive coca queen and the wino is hooked on sour grapes. It appears that most substance abusers are hooked into a belief system regarding the powerful effects of plants on the human organism. These beliefs can be transmuted into a positive force if they are expanded to include plants that can facilitate health. By choosing such plants as comfrey, golden seal, mullein, ginseng and valerian root, the substance abuser can begin to explore a healthier and more natural lifestyle.

In a holistic approach to substance detoxification and rehabilitation, nutrition plays a vital role (Sorensen & Acampora, 1984). Drug addicts/users and alcoholics are notorious for their poor diets, and drugs such as heroin, tobacco, coffee and alcohol deplete the body's store of essential vitamins and minerals. Drugs may produce dietary deficiencies by destroying nutrients, preventing their absorption and increasing their excretion.

In working with drug addicts on improving their diet, it is important to be flexible, non-moralistic and to emphasize a wide variety of wholesome, unrefined and unprocessed foods. White sugar, white flour, excess salt and greasy fried foods should be slowly and gradually eliminated from the diet.

Nutrition is an area conducive to many trends and fads. Probably the most important aspect in helping to change the diet of substance abusers is to avoid rigidity. Simplicity is also important. Small changes in the direction toward a more natural and wholesome diet should be reinforced. In this way substance abusers can learn to listen to their own bodies in terms of their own nutrition needs (Land, 1983).

The therapeutic community emphasizes a drug free lifestyle. The focus is on developing responsibility, discipline, emotional honesty and the appropriate expression of feelings. Unfortunately, most therapeutic communities ignore nutritional factors in their approach. Although there is a strong negative emphasis on drugs such as heroin, alcohol and marijuana, there is considerable abuse of "softer" drugs like coffee, sugar and tobacco.

Since residents of therapeutic communities eat three meals a day in a residential setting, it would seem relatively easy to incorporate principles of good nutrition in these programs. However, food service systems in residential programs usually provide "institutional" foods, high in starches and sugar. A move toward utilizing whole unprocessed foods, herbs and vitamins in therapeutic settings would definitely improve the services rendered.

Changing the dietary patterns in TC's is not easy. This is due to a lack of awareness and inertia. Many TC's are so crisis-oriented that prevention through proper nutrition is a very distant concept. In an experiment at Walden House, natural foods were prepared and the residents' responses were tape-recorded (Nebelkopf, 1978). It was interesting to note that many residents contacted their positive feelings concerning institutional foods. There were many residents who had never eaten three regular meals a day. Such natural foods as toffee and seaweed were received with very negative reactions by the majority of residents. There was, although, a small but vocal minority who expressed very positive feelings toward natural foods. By and large the residents felt that their diet could be improved and that this could enhance their health. What was learned from this experiment was that a move toward natural foods should be slow and simple. There was universal interest in having fresh salads and fruit available, and that brown rice should be substituted for white rice if it was cooked properly.

The training of substance abuse counselors in the principles and practices of alternative health can help them to be more effective with their clients, and can diminish the sense of hopelessness and burnout in the field. The use of herbs, nutrition, bodywork, acupuncture and biofeedback are available and relevant alternatives in the field of substance abuse treatment. The incorporation of these methods geared toward actualizing the whole person in the TC is an important new direction for the eighties.

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NUTRITION AND DIETARY CONCERNS IN THE TC

Donald Land, Ph.D.

Nutrition Information Systems
Marin County, California

Optimum nutrition can improve the effectiveness of staff members and the recovery of residents in a therapeutic community. Contemporary approaches to nutrition, however, must emphasize its effect on brain function, addiction and behavior.

Nutritional approaches to the prevention and treatment of addiction and behavioral problems are becoming increasingly popular but, with few exceptions, have not been taken seriously, or incorporated substantially into treatment by therapeutic communities. These behavioral problems include delinquency, anti-social behavior, learning difficulties, alcoholism and drug addiction.

A healthful approach to treatment is based on a model that empha- sizes:

- developing overall wellness (nutrition, exercise, stress management, relaxation techniques, spiritual health) with diet and nutrition as the central focus;
- dietary and nutritional variables in brain and central nervous system function;
- how poor nutrition can lead to and sustain chemical dependency;
- how wellness and optimum nutrition can increase the success of treatment programs by supporting existing treatment methods; and
- the cost effectiveness of wellness programs.

Contemporary views of addiction are based on a broad formula:

ADDICTION = GENETICS + ENVIRONMENT

- Of these two factors, genetics is essentially fixed but environment is controllable to varying degrees.
- Control of environment means control over, or development of wellness skills.
- A focal point of wellness is nutrition.
- Successful incorporation of nutrition information must be done within a systems or holistic framework. The major interlinking concerns or components in this framework include:

  Diet
  Therapeutic supplements
  Blood sugar and substance abuse
  Food allergy/addiction and substance abuse
  Candida (systemic yeast infection) and substance abuse
  Overall wellness skills
  Staff, resident, outpatient and family training
  Organizational (T.C.) structures that support rather than inhibit wellness

Overall Wellness

The wellness concept of alcoholism or chemical dependency is based on:

- Empowering as well as "fixing" a recovering person
- Operating from a wellness rather than a disease perspective in addition to simply treating the illness
- Envisioning a healthy future -- visualizing oneself as healthy in addition to simply treating the illness
- A focus on optimum rather than simply adequate nutrition

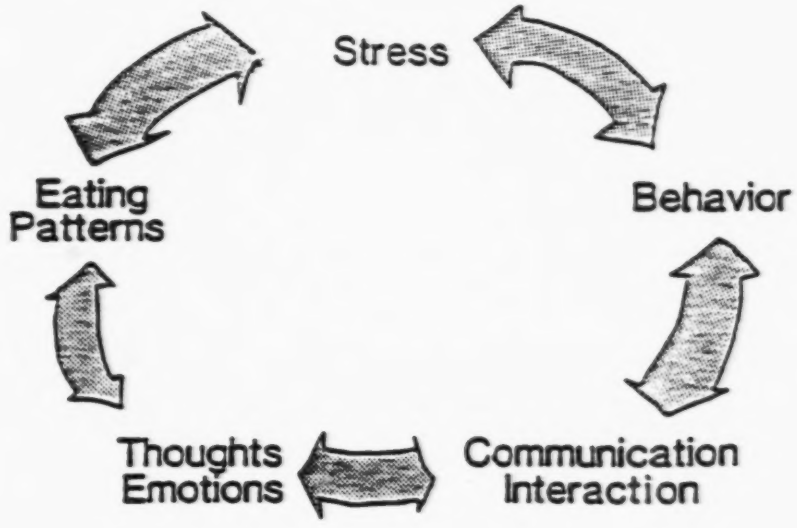
HOLISTIC APPROACHES

Stress Exercise

Nutrition

Relaxation Spirituality

- Whole Food ⟹ Whole Person
- Psychological Balance
- Whole vs Processed Food
- Therapeutic Nutrients



Overall wellness consists of many interlinking activities or practices. Wellness skills are based on what one can do as opposed to what is done to someone.

High Level Recovery means recovery at a level that is optimum -- doing the best that is possible. It means minimizing relapse, depression, physical, mental and emotional dysfunction, and other characteristics of poor or unsuccessful recovery. The difference between various high and low levels of recovery is wellness in general, and optimum nutrition in particular.

Diet and Nutrition in Brain and Central Nervous System Function

Psychonutrition focuses on the link between nutrition and brain function. As a result of this link, poor nutrition can contribute to various physical, mental and emotional symptoms that often lead to and sustain substance abuse. Nutritional imbalance can contribute directly or indirectly to substance abuse, pain, general deterioration and dysfunctional behavior.

On the other hand, optimum nutrition can be the basis of high- level recovery, relapse prevention, prevention of high-risk health conditions and the creation of Wellness and Health Oriented Learning Environments (WHOLE).

While traditional approaches to nutrition are often simplistic, inadequate, and definitely not exciting or empowering, holistic approaches emphasize:

- The importance of whole food (not just vitamins, minerals and processed food) on the whole person
- The link between nutrition and "psychological" problems
- The use of nutrients vs. therapeutic supplements

Poor Nutrition Can Lead to Substance Abuse

Links exist between eating patterns and various aspects of individual performance or functioning: stress, eating patterns, thoughts and emotions, communication/interaction and behavior can interact, both positively and negatively, with every other element.

Some ways of thinking about nutrition and its relationship to addiction and behavior include:

- The question of what relationship one has with a drug, a food or other substance. Optimum nutrition can contribute to a "healthy" (i.e. non-abusive or non-addictive) relationship -- poor nutrition can contribute to the opposite condition.
- The question of whether poor nutrition is related to limited intake of nutrients or to limited ability to utilize nutrients
- The theory that some people are addicted to foods used to mimic their preferred alcoholic beverage.
- The link between nutrition and personality, self-management and coping skills.

Contemporary, holistic concepts are based on several key questions:

- In what way does food allergy/addiction contribute to substance abuse?
- How are eating disorders related to drinking disorders and drug use?
- How does one's biochemical individuality or uniqueness create unique needs for food or nutrients?
- In what way do blood sugar ups and downs contribute to the urge to drink or use drugs?
- How does poor nutrition contribute to psychosocial problems that increase one's risk for abuse or addiction?

NUTRITION FOR OPTIMUM RECOVERY

- Control Hypoglycemia
- Identify Food Sensitivities_
- Therapeutic Supplements
- Whole Foods
- Centered Diet
- A Transition Plan

WELLNESS

- More Than NOT Being Sick
- Proactive

Optimum Nutrition Can Increase the Success of Treatment

Nutritional therapy focuses on:

- Content -- what foods or supplements support recovery

- Process -- values, priorities, routines, relationships and other potential issues involved in to designing and following a food and nutrition program that supports recovery

Therapeutic approaches include the following content issues or questions:

- Can therapeutic doses of certain nutrients eliminate extreme deficiencies (or dependencies) and thereby enhance recovery?

- Can a diet for unstable blood sugar be helpful?

- Is there evidence of food allergy or sensitivity?

- Is there evidence of systemic Candida infection?

- Can amino acids, essential fatty acids (therapeutic oils) or other special supplements enhance recovery?

An optimum plan includes the following: control of hypolgycemia, identification of food sensitivities, therapeutic supplements, whole foods, a centered diet and a transition plan.

Here is a diet that will increase one's risk for substance abuse and dysfunctional behavior:

- 45% fat
- 20% refined sugar
- 12% protein (from 70% animal sources)
- 18% carbohydrates (60% processed)
- 130 pounds of sugar per year (40 teaspoons per day)
- 250 pounds of meat per year (3/4 pound per day)
- 1/3 pound of fat per day

As you might know, it's the Standard American Diet (SAD); it's what the average American consumes. About half of us do worse (i.e., higher risk). Consumption of refined sugar is a major health problem. It is well known that it is a contributor to diabetes, tooth decay, and obesity. But refined sugar also creates impairment in other areas: sensitivity to pain, insomnia, moodiness, fight bacteria, energy, focus.

Most of us "balance" our diets by eating from both extremes:

- Eating a lot from one extreme (salt and animal foods) creates short- and long-term cravings for "foods" on the other extreme (sugar, ale, caffeine, drugs) and vice versa.

- A healthy diet is both balanced and centered, i.e., 80% from the middle of the see-saw and 20% from the extreme ends.

- The Standard American Diet (SAD) is the opposite.

A centered and balanced diet can decrease one's risk for substance abuse, make a major contribution to recovery and to physical, mental and emotional balance and centering.

RUN FOR RECOVERY: AN INSIDER'S VIEW

Frank M.

Walden House
San Francisco, California

For me, this race started two months ago. The first part involved the race to get in shape, and to get other physical needs met. I needed running shoes and clothes, a special diet, vitamins, and permission to train every day. I could not have done all of this without the support of the family, the staff members, and the other runners.

There are many people I would like to thank: Food Services, who helped the runners with our dietary needs, the various individuals who covered me on my job function so that I could train, the family members who did the house G.I.'s on weekends while I trained, John Rios, who was behind this run 110%, and Nick Nelson, who made sure that training time was available on weekends.

I must also commend the other runners for their high degree of commitment. Excluding one unexpected injury and one person who left while the house was on containment, we had only one person drop out of the running team. Everyone else trained hard, and finished the race. A high degree of commitment indeed!

On Sunday morning, I woke up early, and when I looked out of my bedroom window, I was greeted by a perfect day. I knew that this would be a challenging race for me, and that I would have to watch my pace. I had a light breakfast, in the hope that it would make a difference, and also found that I had a hard time keeping away from cigarettes. I was feeling some pre-race anxiety.

The runners from Walden House decided to walk to the Polo Fields, in order to warm up our legs. I also noticed pre-race anxiety in my comrades. As we walked along, there was a lot of laughing, joking and kidding. It seemed like a good act-as-if to me, to cover the anxiety among us.

When I arrived at the Polo Fields, there was some discretion as to what the actual course would be, since it had changed and was different from the map sent to me. But I was assured by an official that the course would be well marked and monitored, and with that issue out of the way, I went to the starting line to warm up.

There were approximately three hundred runners at the starting line, but in my mind there appeared to be more. I made a decision to start at a slow pace, as this was to be my first 10k race, and I was here for the experience. Any chances of winning was already out of my mind.

When the starting gun sounded, I took off. I started at a slow pace, but found it difficult not to run faster, as many people were passing me.

Although I didn't like being passed by other runners, I knew that a faster pace would eventually take its toll, so I kept to a moderate pace. At the first turn, I heard a familiar sound, the combination of running shoes slapping pavement, and air rushing through mouth and nostrils. When I looked over my shoulder, there was Jack H. coming on strong.

When he came alongside me, I said to him," Slow it down a bit, Jack, when they hit the hill, they'll be dropping like flies." I ran with him briefly, but his pace was too fast for me, so I let up and ran at my pace. At the second turn I greeted Paul C. who was monitoring, and I turned right and headed east on Kennedy Drive. I was feeling good at that point, having warmed up properly before the race, and as I passed the one mile marker, I saw my girlfriend, Sandy, who was there to cheer me on. I wanted to stop and talk to her, but I fought the impulse and continued on.

And then came the hill. Now, I have to tell us this: when driving east from the back on Kennedy Drive, between Lakes Drive and Traverse Drive, or when walking that same segment, it doesn't appear to be much of a hill, it doesn't look like a hill at all, a gentle rise maybe. But try running that distance, fast, or slow. At any speed above a walk, that gentle rise turns into a hill. So I slowed down, controlled my breathing, and I made it! And somewhere between there and the three mile marker, I passed Jack H. I was going down hill now, so I picked up my pace. I passed the start line, and was back at the first turn again, then the second turn and then back up Kennedy Drive. But this time it was different. After four miles, any physical reserve I had was already spent. My left foot was slowly going numb, and I was finding it very difficult to breath. So I slowed down, and then I had to slow down some more. I don't remember where Jack H. passed me, but I

remember where George R. passed me. It was at Lindsley Meadows, and when he passed me, I felt demoralized and humble. I knew that I was faster than George but I had underestimated his endur-ance and overestimated my own. And I was also feeling embarrassed. It was a blow to my ego when George passed me. Real clinical stuff!

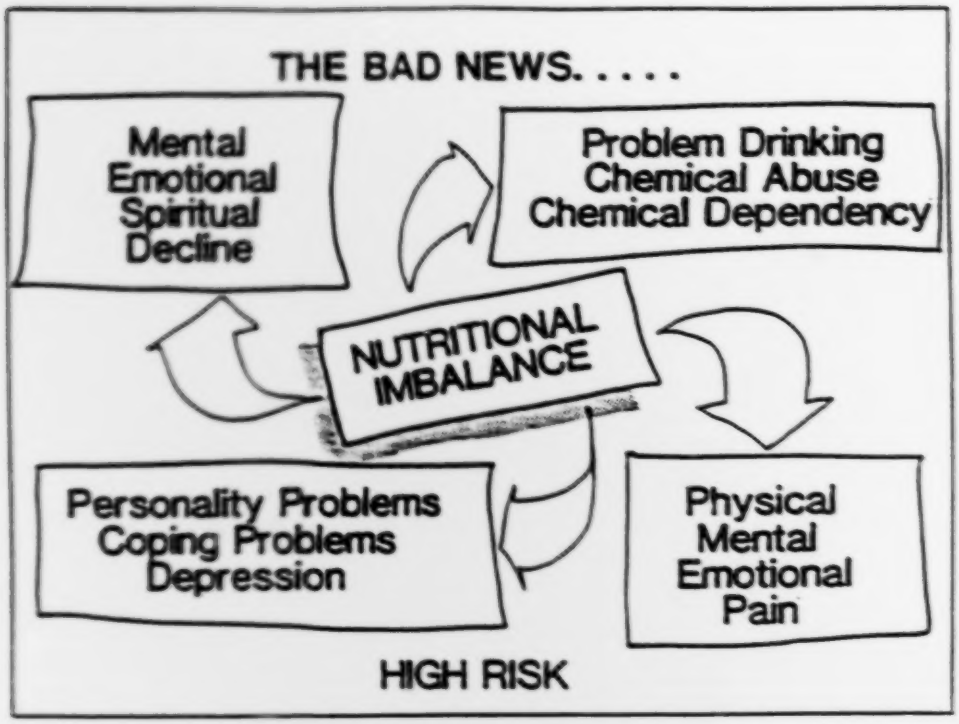
So shortly after he passed me, I stopped running, and walked for a minute to catch my breath. I started again, and had to stop one more time, and when I continued again, at a slow pace, I regained my composure and my ability to finish the race. I turned on Traverse Drive, and turned again on Middle Drive, where I found it easy to pick up my pace again, until I found a comfortable stride. I made it to the finish line at that speed, and received a spiritual boost when I heard the cheers of the Walden House family as I crossed that last marker.

The satisfaction and joy I felt soon turned into concern, when I came upon a group of people standing around Charlie T., who was on the ground.

Charlie had apparently put out all that he had, and collapsed after crossing the finish line. He was semi-conscious for ten to fifteen minutes. It hurt me to see him in that condition. He slowly regained consciousness, and under advisement from the paramedic on hand, he was sent to a hospital for a complete check up.

When the awards were given out, Elizabeth S. received a gold medal for first place in the Womans' Recovery Division. George R. won a dinner for four in the raffle.

My reward was the personal satisfaction I felt, and the encouragement I received from my teammates and friends. I also feel that the high degree of commitment by the runners, and the high degree of support from the family and staff will set a standard for all who will follow us in the future.


THE BAD NEWS. . . . .
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Chemical Abuse
Chemical Dependency
NUTRITIONAL
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Personality Problems
Coping Problems
Depression
Physical
Mental
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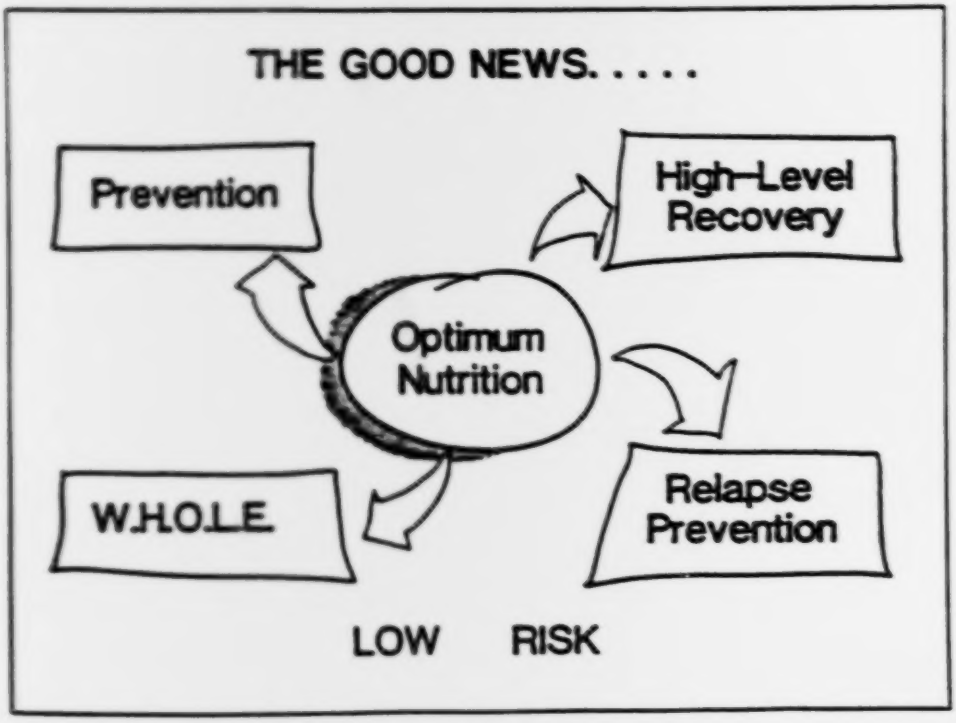
Pain
HIGH RISK


THE GOOD NEWS. . . . .
Prevention
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Relapse
Prevention
LOW RISK